New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name _____ Date _____ Email _____

Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address _____ City _____State _____Zip Code _____
Telephone (work) _____ (home) _____ Referred By _____
Age _____ Birth date _____ Social Security # _____ Number of children _____
Occupation _____ Employer_____
Marital Status _____ Spouse's name _____ Spouse's Occupation _____
Spouse's employer _____ Spouse's health status _____
Emergency contact _____ Phone _____

Current Complaints

Nature of injury: Automobile* ❑ Work ❑ Other ❑
Please describe _____
_____
Date of injury _____ Date symptoms appeared _____
Have you ever had same condition? ❑ No ❑ Yes If yes, when? _____
List other practioners seen for this injury/condition _____
Have you ever been under chiropractic care? ❑ No ❑ Yes
If yes, please describe

Signature

Payment is due at time services are provided unless prior arrangements have been made. I certify that all information above is true and accurate.

Print Name_____
Signature_____ Date_____

Medical History

Have you been treated for any conditions in the last year? ❑ No ❑ Yes
If yes, please describe _____
Date of last physical exam _____. Is there a chance that you are pregnant? ❑ No ❑ Yes
Have you had X-rays taken? ❑ No ❑ Yes If yes, where? _____
What medications are you taking and for what conditions (Please list dosage and amounts, etc).
_____
_____
_____
What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).
_____
_____

Have you ever:	No	Yes	Briefly Explain
Broken bones?	❑	❑	_____
Been hospitalized?	❑	❑	_____
Been in an auto accident?	❑	❑	_____
Had Sprains/Strains?	❑	❑	_____
Been struck unconscious?	❑	❑	_____
Had surgery?	❑	❑	_____

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	❑ No ❑ Yes
Do your symptoms interfere with daily life?	❑ No ❑ Yes
Does pain wake you up at night?	❑ No ❑ Yes
Are your symptoms worse during certain times of the day?	❑ No ❑ Yes
Do changes in weather affect your symptoms?	❑ No ❑ Yes
Do you wear orthotics?	❑ No ❑ Yes
Do you take vitamin supplements?	❑ No ❑ Yes
What activities aggravate your symptoms?	❑ No ❑ Yes
_____	
_____	
_____	

Habits	None	Light	Moderate	Heavy
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑
Soft Drinks	❑	❑	❑	❑
Water	❑	❑	❑	❑
Salty Foods	❑	❑	❑	❑
Sugary Foods	❑	❑	❑	❑
Artificial Sweeteners	❑	❑	❑	❑

Have you ever suffered from:

- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain
- ❑ Breast lump
- ❑ Bronchitis
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chest Pain/Conditions
- ❑ Cold extremities
- ❑ Constipation
- ❑ Cramps
- ❑ Depression
- ❑ Diabetes
- ❑ Digestion Problems
- ❑ Dizziness
- ❑ Ears Ring
- ❑ Excessive Menstruation
- ❑ Eye Pain/Difficulties
- ❑ Fatigue
- ❑ Frequent Urination
- ❑ Headache
- ❑ Hemorrhoids
- ❑ High Blood Pressure
- ❑ Hot Flashes
- ❑ Irregular Heart Beat
- ❑ Irregular Cycle
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Loss of memory Loss of balance
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Lumps In Breast
- ❑ Neck Pain or Stiffness
- ❑ Nervousness
- ❑ Nosebleeds
- ❑ Pacemaker
- ❑ Polio
- ❑ Poor Posture
- ❑ Prostate Trouble
- ❑ Sciatica
- ❑ Shortness of breath
- ❑ Sinus Infection
- ❑ Sleep problems/insomnia
- ❑ Spinal Curvatures
- ❑ Stroke
- ❑ Swelling of ankles
- ❑ Swollen Joints
- ❑ Thyroid Condition
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Varicose Veins
- ❑ Venereal Disease
- ❑ Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing