New Patient Health History Form

Patient Data: **Last Name**_____ **First Name**_____ **Date:** _____

Email: _____ **Best Phone#:** _____

Address _____ City_____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Age _____ Birthdate _____ SS# _____

Occupation _____ Employer _____

Marital Status _____Are you Pregnant? _____ Number of children_____

Emergency Contact _____ Phone _____

Who may we thank for referring you to us? _____

Insurance Information

Name of party responsible for payment _____

Do you have health insurance? _____ Name of insurance company _____ Id # _____

If an auto accident, please provide:

Insurance Company Name _____ Contact Person _____

Phone _____ Claim # _____ Date of Accident_____

Current Complaints

Nature of Injury: Automobile _____ Work _____ Other _____

Date of Injury: _____

Please describe:

Date symptoms appeared _____ Are they getting worse?_____

List other practitioners you have seen for this injury/condition _____

Have you ever been under chiropractic care? Yes ____ No _____ Do you experience pain every day? _____

Do your symptoms interfere with your (please circle): Work Play Sleep Daily Routine

Does pain wake you or keep you up at night? _____

Are your symptoms worse during certain times of the day? _____

Do changes in weather affect your symptoms? _____

What activities aggravate your symptoms? _____

Please Check Treatment Goals:

Reduce Acute Pain _____ Reduce Muscle Spasm _____ Increase Range of Motion _____

Manage Chronic Pain _____ Correct Posture _____ Reduce Reliance on Narcotics _____

Stabilization_____ Reduce Disc Herniation_____ Prevention and Wellness_____

Signatures

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable.

I authorize the release of pertinent medical information, such as Diagnosis, necessary to process claims from this office.

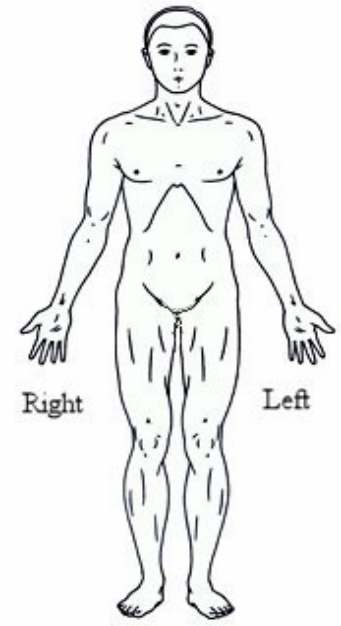
Patient or Guardian Printed Name _____Signature _____ Date _____

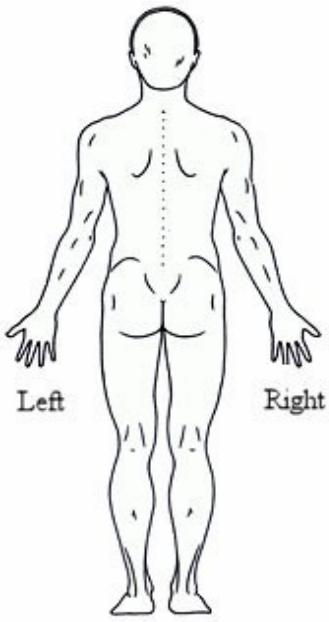
Patient Name _____Date_____

Current Symptoms

Pain Diagram and Rating. (0-10 with 10 being the worst pain)

Mark Type of Pain: **S**tabbing **B**urning **N**umb **T**ingling **A**chey





Neck Pain
0 1 2 3 4 5 6 7 8 9 10

Shoulder, Arm Pain
0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain
0 1 2 3 4 5 6 7 8 9 10

Low Back Pain
0 1 2 3 4 5 6 7 8 9 10

Hip, Leg Pain
0 1 2 3 4 5 6 7 8 9 10

Other Pain
_____
0 1 2 3 4 5 6 7 8 9 10

Medical History

Have you been treated for any conditions in the last year? Yes _____ No _____
If yes, please describe:

Date of last physical exam :_____ Have you had x-rays taken? Yes _____ No _____
What medications, including supplements, are you currently taking and for what conditions? Please list:
_____

Do you smoke? _____ How much? _____For how long? _____

Have you Ever:			**Briefly Explain**:
Broken bones?	Y	N	_____
Been hospitalized?	Y	N	_____
Been in an auto accident?	Y	N	_____
Had Sprains/Strains?	Y	N	_____
Been struck unconscious?	Y	N	_____
Had surgery?	Y	N	_____

Please mark any of the following conditions or symptoms that you have now or have experienced:

__ AIDS
__ Allergies
__ Anxiety
__ Arteriosclerosis
__ Asthma
__ Cancer
__ Cold Hands or Feet
__Concussion
__ Constipation
__ Depression
__ Diabetes
__ Diarrhea
__Disc Herniation
__ Dizziness
__ Epilepsy
__ Fatigue
__Headaches
__ Heart Attack
__ High Blood Pressure
__ Irregular Periods
__ Jaw/TMJ Problems
__Loss of Balance
__ Loss of Smell or Taste
__ Low Back Pain
__Mid Back Pain
__Migraine
__Miscarriage
__Nausea
__ Neck Pain
__ Nervousness
__ Numbness in Hands or Arms
__ Numbness in Legs or Feet
__ Osteoporosis
__ Pain in Hands or Arms
__ Pain in Legs or Feet
__ Ringing in Ears
__ Shoulder Pain
__ Sinus problems
__ Sleeping Problems
__ Stenosis
__ Stroke
Other_____