New Patient Health History Form

Patient Data

First Name_____Last Name_____Date_____Email_____

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

Mailing Address

Address_____City_____State____Zip_____Birth Date_____

Age_____Sex_____Cell Phone_____Home Phone_____Work Phone_____

SS#_____Occupation_____Employer_____

Number of children_____Marital status_____Spouse's Name_____Referred By_____

Emergency Contact_____Phone_____

Current Complaints

Nature of Injury ____Auto____Work____Other Please describe_____

_____

Date of Injury_____Date symptoms appeared_____Have you had the same condition?___YES___NO

If yes, when?_____Have you ever been under chiropractic care?_____

List other practitioners seen for this injury/condition_____

Insurance Information

Name of party responsible for payment_____phone_____

Do you have health insurance?____YES____NO Name of company_____

Subscriber's Name_____DOB_____Policy ID#_____Employer_____

Do you have a secondary health insurance?____YES____NO If yes, Insurance Company Name_____

Subscriber Name_____DOB_____Policy ID#_____Employer_____

Signatures

Name of the insured_____ _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. 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/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature_____Date_____

Spouse's or Guardian's Signature_____Date_____

Medical History

Have you been treated for any conditions in the last year?_____YES_____NO If yes, please describe_____

_____

Date of last physical exam_____Blood work_____Is there a chance you are pregnant?____YES____NO

Have you had X-rays taken?____YES____NO If yes, where?_____Please list all medications you

are taking and for what conditions_____

_____

What vitamins, minerals, or herbs do you currently take?_____

Have you ever:

Broken bones?___YES___NO briefly explain_____
Been hospitalized?___YES___NO briefly explain_____
Been in an auto accident?___YES___NO briefly explain_____
Had sprains/stains?____YES____NO briefly explain_____
Had head injuries?___YES___NO briefly explain_____
Had any surgeries? ___YES___NO briefly explain_____

Family History

Please list any past or present health conditions of your parents (example: heart disease, cancer, diabetes, arthritis, etc.)

_____

_____

Habits

Alcohol	___NONE___LIGHT___MODERATE___HEAVY
Coffee	___NONE___LIGHT___MODERATE___HEAVY
Tobacco	___NONE___LIGHT___MODERATE___HEAVY
Drugs	___NONE___LIGHT___MODERATE___HEAVY
Exercise	___NONE___LIGHT___MODERATE___HEAVY
Sleep	___NONE___LIGHT___MODERATE___HEAVY
Appetite	___NONE___LIGHT___MODERATE___HEAVY
Soft drinks	___NONE___LIGHT___MODERATE___HEAVY
Water	___NONE___LIGHT___MODERATE___HEAVY
Salty foods	___NONE___LIGHT___MODERATE___HEAVY
Sugary foods	___NONE___LIGHT___MODERATE___HEAVY
Artificial Sweeteners	___NONE___LIGHT___MODERATE___HEAVY

Have you ever suffered from:

___Alcoholism
___Allergies
___Anemia
___Arteriosclerosis
___Arthritis
___Back pain
___breast lump
___bronchitis
___bruise easily
___cancer
___chest pain/conditions
___constipation
___cramps
___depression
___diabetes
___digestion problems
___dizziness
___ringing in ears
___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
___nose bleeds
___pacemaker
___polio
___poor posture
___prostate trouble
___sciatica
___shortness of breath
___sinus infection
___sleep problems
___spinal curvatures
___stroke
___swelling of ankles
___swollen joints
___thyroid condition
___tuberculosis
___ulcers
___varicose veins
___venereal disease
___other