

**New Patient Health History**

Name: \_\_\_\_\_ What do you prefer to be called? \_\_\_\_\_

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Email Address: \_\_\_\_\_ Spouses Name: \_\_\_\_\_

Spouses Employer: \_\_\_\_\_ Spouses phone number: \_\_\_\_\_

Insurance Policy Holder's Name: \_\_\_\_\_ Insured's Phone: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_ Referred by: \_\_\_\_\_

Past Chiropractic Care?  yes  No If so, when? \_\_\_\_\_ Doctor's Name: \_\_\_\_\_

Results? \_\_\_\_\_

Is the injury work related?  Yes  No If so, please see the front desk staff now for further information.

Please list any accidents or falls as well as the date of incident:

\_\_\_\_\_

Please list any bone fractures or dislocations:

\_\_\_\_\_

Have you ever had X-Rays taken? \_\_\_\_\_ If so, when? \_\_\_\_\_ Where? \_\_\_\_\_

Please circle if you have you ever had an MRI, EMG, and/or a CT Scan. If so, when? \_\_\_\_\_

Where? \_\_\_\_\_

For what ailments were these x-rays made? \_\_\_\_\_

Do you wear orthotics or heel lifts? \_\_\_\_\_ If so, fitted by whom? \_\_\_\_\_

Do you suffer from any condition other than that for which you are now consulting us?

\_\_\_\_\_

Are you presently taking any medications, prescriptions, over – the – counter, home remedies, vitamins, etc.?

Y  N If so, please list: \_\_\_\_\_

Have you had any major surgeries related to the spine, heart, joint etc.? \_\_\_\_\_ if so, please list:

\_\_\_\_\_

Diagnosis (Blood Pressure, Cholesterol, Diabetes):

\_\_\_\_\_

\_\_\_\_\_

Please turn over and complete the backside of this form as well. Thank you!

Please check any that apply.

**Heart & Vascular:**

- High blood pressure
- Stroke
- Irregular heart beat
- Circulatory problems
- Low blood pressure
- Chest pain
- Heart trouble
- Strokes
- Swelling ankles

**Respiratory:**

- Chronic Cough
- Difficulty breathing
- Asthma
- Coughing up phlegm
- Coughing up blood

**Musculoskeletal**

- Backache
- Foot trouble
- Hernia
- Shoulder blade pain
- Painful tailbone
- Stiff neck or neck pain
- Spinal curvature
- Swollen Joints
- Tremors/twitching
- Joint pain
- arthritis

**Neuromuscular:**

- Bronchitis
- Tender/swollen lymph nodes
- Depression
- Dizziness

- Fainting
- Fatigue
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Night sweats
- Numbness/pain in arms, hands, or legs
- Wheezing
- Seizures
- Memory loss
- History of fainting

Other mental illness:

**Eye/Ear/Nose/Throat:**

- Deafness
- Earache
- Ear discharge
- Ear noises
- Thyroid problems
- Frequent colds
- Hay fever
- Nasal obstruction
- Eye pain
- Poor vision
- Blurred vision
- Sinus trouble
- Sore throats
- Tonsillitis

**Integumentary (Skin):**

- Bruising easily
- Dryness
- Eczema
- Itching
- Sensitive skin

**Allergies**

- None
- \_\_\_\_\_

**Gastro-Intestinal:**

- Belching/gas
- Difficulty swallowing
- Colon trouble
- Constipation
- Diarrhea
- Gall bladder trouble
- Liver trouble
- Nausea
- Stomach pain
- Vomiting
- Heart burn
- Bloody stools
- Acid reflux
- Irritable bowel

**Genito-Urinary:**

- Blood in urine
- Frequent urination
- Inability to control urine
- Kidney infection
- Kidney stones
- Painful urination
- Prostrate trouble

**Females Only:**

- Cramps
- Hot flashes
- Pregnant at this time

Due Date: \_\_\_\_\_

**History of Cancer or any other major medical condition:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Habits:**

- Smoking (packs/day: \_\_\_\_\_)
- Alcohol (glasses/day: \_\_\_\_\_)
- Coffee (cups/day: \_\_\_\_\_)
- Soft Drinks (cans/day: \_\_\_\_\_)
- Water (glasses/day: \_\_\_\_\_)

**Exercise:**

- None
- Moderate
- Daily

**Family History**

	Diabetes	Kidney	Cancer	Back
Mom: _____	_____	_____	_____	_____
Dad: _____	_____	_____	_____	_____
Brother: _____	_____	_____	_____	_____
Sister: _____	_____	_____	_____	_____

I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider will/will not prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid, directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsibility for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the uses of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor for imaging is for examination only, and only the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_