New Patient Health History Form

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

Patient Data

First Name | Last 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

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 of other practitioners seen for this injury/condition

Have you ever been under chiropractic care? ◯ No ◯ Yes

If yes, please describe

Insurance Information

Name of party responsible for payment | Phone

Do you have health insurance? ◯ No ◯ Yes Name of company

*** If an auto accident, please provide:**

Insurance Company Name | Contact Person

Phone: | Claim #

Signatures

Name of the insured _____

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/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? ◯ 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)I

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, 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 Members - 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?

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:

Constitutional
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Eyes
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

Cardiovascular
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins
- ☐ Other

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

Musculoskeletal
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

Integumentary
- ☐ Breast Lumps / Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ History of Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

ENMT
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ TMJ problems
- ☐ Mouth Ulcers

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stool Color Change
- ☐ Stool Consistency Change
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Urgency / Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostrate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

Neurological
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

Psychiatric
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

Endocrine
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

Hematologic / Lymphatic
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting Disorder
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

Allergic / Immunologic
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

_____

_____

_____

_____

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

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