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 if 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?

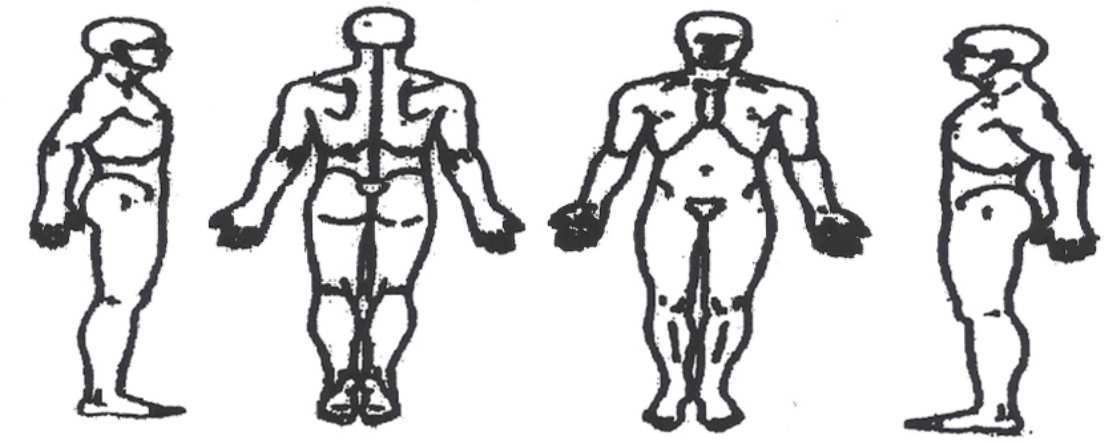
Habits	None	Light	Moderate	Heavy
Alcohol	◯	◯	◯	◯
Coffee	◯	◯	◯	◯
Tobacco	◯	◯	◯	◯
Drugs	◯	◯	◯	◯
Exercise	◯	◯	◯	◯
Sleep	◯	◯	◯	◯
Appetite	◯	◯	◯	◯
Soft Drinks	◯	◯	◯	◯
Water	◯	◯	◯	◯
Salty Foods	◯	◯	◯	◯
Sugary Foods	◯	◯	◯	◯
Artificial Sweeteners	◯	◯	◯	◯

Patient Intake Form

Patient Name _____ **Date** _____

1. Is today's problem caused by? ☐ Auto Accident ☐ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

☐ **Constantly (76-100% of the time)** ☐ **Occasionally (26-50% of the time)**

☐ **Frequently (51-75% of the time)** ☐ **Intermittently (1-25% of the time)**

4. How would you describe the type of pain?

☐ **Sharp** ☐ **Numb**

☐ **Dull** ☐ **Tingly**

☐ **Diffuse** ☐ **Sharp with motion**

☐ **Achy** ☐ **Shooting with motion**

☐ **Burning** ☐ **Stabbing with motion**

☐ **Shooting** ☐ **Electric like with motion**

☐ **Stiff** ☐ **Other** _____

5. How are your symptoms changing with time?

☐ **Getting Worse** ☐ **Staying the Same**

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please Circle)

7. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. How much has the problem interfered with your Social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. Who else have you seen for your problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician

☐ ER Physician ☐ Orthopaedist ☐ Other _____

☐ Massage Therapist ☐ Physical Therapist ☐ No one

10. How long have you had this problem?

_____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

☐ Yes ☐ Yes, at times ☐ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height _____ **Weight** _____ **Date of Birth** _____

Occupation _____

16. How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

17. What type of exercise do you do?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair

18. Indicate if you have any immediate family members with any of the following;

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus

☐ Heart Problems ☐ Cancer ☐ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present							
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Smoking/Tobacco Use
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Allergtes
☐	☐	Elbow/ Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Systemic Lupus
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Epllepsy
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Dermatits/Eczema/Rash
☐	☐	Hip Pain	☐	☐	Loss of Bladder Control	☐	☐	Hiv/Aids
☐	☐	Upper Leg Pain	☐	☐	Prostate Problems	For Females Only		
☐	☐	Knee Pain	☐	☐	Abnormal Weight Gain/Loss	☐	☐	Birth Control Pills
☐	☐	Ankle/Foot Pain	☐	☐	Loss of Appetite	☐	☐	Hormonal Replacement
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	☐	☐	Pregnancy
☐	☐	Join Pain / Stiffness	☐	☐	Ulcer			
☐	☐	Arthritis	☐	☐	Hepatitis			
☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder			
☐	☐	Cancer	☐	☐	General Fatigue			
☐	☐	Tumour	☐	☐	Muscular Incoordination			
☐	☐	Asthma	☐	☐	Visual Disturbances			
☐	☐	Chronic Sinusitis	☐	☐	Dizziness			
☐	☐	Other						

20. List all prescription medications you are currently taking:

21. List all of the over-the-counter medications you are currently taking:

22. List all surgical procedures you have had:

23. What activities do you do at work?

☐ **Sit**	☐ **Most of the day**	☐ **Half of the day**	☐ **A little of the day**
☐ **Stand**	☐ **Most of the day**	☐ **Half of the day**	☐ **A little of the day**
☐ **Computer Work**	☐ **Most of the day**	☐ **Half of the day**	☐ **A little of the day**
☐ **On the phone**	☐ **Most of the day**	☐ **Half of the day**	☐ **A little of the day**

24. What activities do you do outside of work?

25. Have you ever been hospitalized? ☐ **NO** ☐ **Yes**

If yes, why

26. Have you had significant past trauma? ☐ **NO** ☐ **Yes**

27. Anything else pertinent to your visit today?

Patient Signature **Date**