New Patient Health History Form

To provide you the best possible wellness 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___________________

Mailing address

Address____________________________ City______________________________ State_________ Zip___________

Telephone (Home)_______________________ (Cell)______________________ (Work)______________________

Birth Date_____/_____/________ Social Security #__________________ Referred By________________________

Occupation____________________________________ Employer____

Marital Status_____________________ Spouse's Name____

Emergency Contact___________________________________ Phone_______________________________________

*To opt in for reminder texts, please provide your cell phone carrier. Standard text message rates may apply:

Cell phone carrier___________________________________

**For *Language, Race, and Ethnicity*, leave blank if you do not wish to specify:

Language________________________ Ethnicity_________________________ Race________________________

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

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.)

____

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________________________

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: mother – cancer – living or deceased?)

____

____

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
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	☐	☐	☐	☐
Stress	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Nutrition	☐	☐	☐	☐
Exercise	☐	☐	☐	☐

Signature____ Date_________________