



## New Patient Health History Form

### Patient Information

Date \_\_\_\_\_ ID # (office use) \_\_\_\_\_  
Name \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
What is the best time to reach you? \_\_\_\_\_ What number is best to reach you?  Home  Cell  Work  
Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_  
Marital Status: Single Married Separated Divorcee Widowed  
Patient's Occupation \_\_\_\_\_ Patient's Employer \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Email (if different): \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_  
Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Emergency Contact Phone # \_\_\_\_\_  
Who referred you or how did you learn of our office? \_\_\_\_\_

### Insurance Information

Name of party responsible for payment \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Phone # \_\_\_\_\_  
Name of insurance company \_\_\_\_\_  
Group # \_\_\_\_\_ ID # \_\_\_\_\_  
Is patient covered by additional health insurance?  Yes  No  
Name of insurance company \_\_\_\_\_ Subscriber's name \_\_\_\_\_  
Subscriber's Birthdate \_\_\_\_\_ Subscriber's SS # \_\_\_\_\_  
Group # \_\_\_\_\_ ID # \_\_\_\_\_

**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. I hereby authorize the doctor to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all insurance submissions.**

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_  
Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**Accident Information**

Is condition due to an accident?  Yes  No Date of accident \_\_\_\_\_

To whom have you made a report of your accident?

Auto Insurance  Employer  Worker Comp  Other \_\_\_\_\_

If an auto accident please provide 3<sup>rd</sup> party auto-insurance:

Patient's Auto Insurance Name \_\_\_\_\_ Phone # \_\_\_\_\_

Contact person \_\_\_\_\_ Claim # \_\_\_\_\_

Patient's Attorney Name \_\_\_\_\_ Phone # \_\_\_\_\_

3<sup>rd</sup> Party involved in accident:

3<sup>rd</sup> Party Auto Insurance Name \_\_\_\_\_ Claim # \_\_\_\_\_

3<sup>rd</sup> Party Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_

**Patient Current Condition**

Briefly describe your major complaint, its location and the effect it has had on your life: \_\_\_\_\_

How long has this condition been present? \_\_\_\_\_ Have you ever had this condition in the past?  Yes  No

What do you think is the cause of your problem? \_\_\_\_\_

If you are experiencing pain, is it :

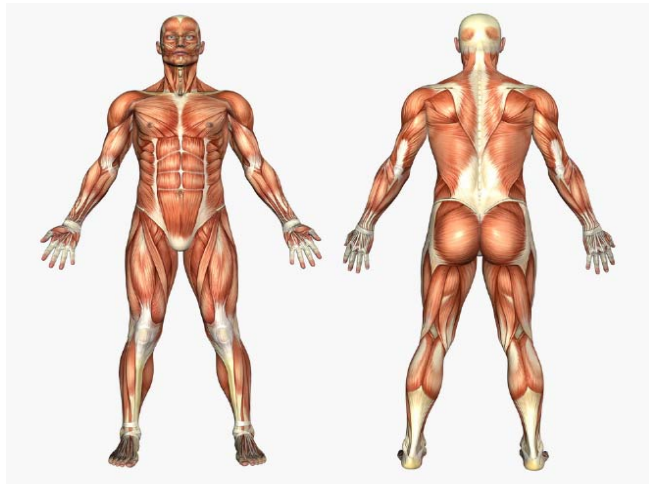
Sharp  Dull  Tingling  Burning  Throbbing  Cramps  Numbness  Stiffness

Aching  Swelling  Shooting  Other \_\_\_\_\_

Rate intensity on a scale of 1 -10 (1 = low and 10 = high) \_\_\_\_\_ Morning \_\_\_\_\_ Afternoon \_\_\_\_\_ Night

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

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



Has your condition been the same or worse and at any particular time? \_\_\_\_\_

What specific life activities does it interfere with  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down

Is this related to a motor vehicle accident?  Yes  No Is it related to a Worker's Comp Injury?  Yes  No

Please complete attached forms for either motor vehicle accident or Worker's Comp Injury

Have you been seen by other doctors for this problem? Please list:

Chiropractor Name \_\_\_\_\_ Phone \_\_\_\_\_

Medical Facility Name \_\_\_\_\_ Phone \_\_\_\_\_

### Medical History

Have you been treated for any conditions in the last year?  Yes  No

If yes, please describe \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Is there a chance that you are pregnant?  Yes  No

Have you had X-rays taken?  Yes  No If yes, where? \_\_\_\_\_

Please list any medication you are you taking.


What vitamins, minerals, or herbs do you currently take? Please list \_\_\_\_\_

List surgeries, broken bones and major illnesses (including childhood):

- Accidents/Falls \_\_\_\_\_ Date \_\_\_\_\_
- Head Injuries \_\_\_\_\_ Date \_\_\_\_\_
- Broken Bones \_\_\_\_\_ Date \_\_\_\_\_
- Dislocations \_\_\_\_\_ Date \_\_\_\_\_
- Surgeries \_\_\_\_\_ Date \_\_\_\_\_

Have you ever been hospitalized?  Yes  No If yes, please explain: \_\_\_\_\_

Symptoms: C = Current P = Past

- |                                       |  |  |   |   |
|---------------------------------------|--|--|---|---|
| <input type="checkbox"/> Aids/HIV     | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia       | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disk      | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Anorexia     | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tumors           |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Polio                | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Varicose Veins   |
| <input type="checkbox"/> Blood Clots  | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Jaw Pain/TMU        | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Whiplash         |
| <input type="checkbox"/> Breast Lump  | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Bronchitis   | <input type="checkbox"/> Gout                | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Rheumatic Fever      |   |
| <input type="checkbox"/> Bulimia      | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Scarlet Fever        |   |
| <input type="checkbox"/> Caner        | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Stroke               |   |

Habits: N = None L = Light M = Moderate H = Heavy

- |                                  |                                   |                                       |                                      |
|----------------------------------|-----------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Exercise | <input type="checkbox"/> Water        | <input type="checkbox"/> Soft Drinks |
| <input type="checkbox"/> Coffee  | <input type="checkbox"/> Sleep    | <input type="checkbox"/> Salty Foods  | <input type="checkbox"/> Chocolate   |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Appetite | <input type="checkbox"/> Sugary Foods | <input type="checkbox"/> Other       |

### Family History

Does your family have any conditions like diabetes, cancer, heart disease, thyroid, gastro intestinal disease, scoliosis or cholesterol ect...

Family Member	Present and past health conditions