New Patient Health History Form

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

Patient Information

First Name ______________________ Last Name ______________________ Date_________

Telephone (Cell)________________ (home)_________________ (work)__________________

Email* ____

* Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Address____

City ________________________________ State ________________ Zip ________________

Age _________ Birth Date _________________ Social Security # _______________________

Occupation _______________________ Employer ___________________________________

Spouse's Name __________________________________ Phone _______________________

Emergency Contact _______________________________ Phone ______________________

Insurance Information

Do you have health insurance? ☐ No ☐ Yes

Are you the Plan's Subscriber? ☐ No ☐ Yes

Relationship to Subscriber ☐ Self ☐ Spouse ☐Child ☐ Other

Name of Insurance Suscriber____

Subscriber's Date of Birth ______________________________ Phone ___________________

Name of Company ____

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

Insurance Company Name ____

Contact Person Name _________________________________ Phone ___________________

Claim # _______________________________________

Signatures

I, Patient (please print)____ 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/terminate my care/treatment, any fees for professional services rendered to me will be immediately due.

Patient's Signature ______________________________________ Date _________________

Parent/Guardian's Signature ______________________________ Date ________________

Current Complaints

Nature of Injury:

- ☐ Automobile
- ☐ Work
- ☐ Sport
- ☐ Accidental injury
- ☐ Chronic pain
- ☐ Illness

Where is the pain located?

- ☐ Neck
- ☐ Head
- ☐ Upper Back
- ☐ Low Back
- ☐ Pelvis
- ☐ Hip
- ☐ Groin
- ☐ Leg
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Shoulder
- ☐ Arm
- ☐ Wrist
- ☐ Hand

Type:

- ☐ Torn Ligaments/Muscle
- ☐ Fracture
- ☐ Other - Please Describe
- ☐ Broken bone
- ☐ Sprain/Strain
- ☐ Spinal Curvature
- ☐ Nerve Damage

____

What does the pain feel like?

- ☐ Aching
- ☐ Burning
- ☐ Stabbing
- ☐ Numbness
- ☐ Tingling
- ☐ Headaches
- ☐ Dull
- ☐ Sharp
- ☐ Other

What activities aggravate your symptoms?

- ☐ Standing (long periods)
- ☐ Walking/Running
- ☐ Sitting/Desk Work
- ☐ Repetitive Movements
- ☐ Sports
- ☐ Gym Exercise
- ☐ Carrying heavy items
- ☐ Home Chores
- ☐ Playing with kids
- ☐ Sedentary Lifestyle
- ☐ Traveling
- ☐ Sleeping Position

Date of Injury ______________________ Date symptoms appeared _________________________

Do you experience pain daily? ☐ No ☐ Yes

Do your symptoms interfere with daily life? ☐ No ☐ Yes

Does pain wake you up at night? ☐ No ☐ Yes

Do changes in weather affect your symptoms? ☐ No ☐ Yes

Are your symptoms worse during certain times of the day? ☐ Morning ☐ Mid-day ☐ Night

Do you wear orthotics? ☐ No ☐ Yes

Medical History

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

If yes, please describe ____

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

Have you had X-rays taken? ☐ No ☐ Yes