## 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.

First Name Date   Part Email*      * Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.   Mailing address   Address   Address   Address   City   State   Spouse   Spouse's Cocupation   Cocupation   Spouse's Spouse's Name   Spouse's Spouse's Cocupation   Marital Status   Spouse's Spouse's Name   Spouse's Employer   Emergency Contact   Phone     Current Complaints   Nature of Injuy:   Automobile*   Work   Other   Please describe:   Date if Injuy   Date symptoms appeared   Have you ever had same condition?   No<   Yes   It yes, please describe   Insurance Information   Name of party responsible for payment   Day ou have health insurance?   No   Yes   Name of party responsible for payment   Contact Person   Phone:   Claim #	Patient Data				
Mailing address         Address       City       State       Zip         Telephone (Work)       ('home)       Reterred By       Age         Birth Date       Social Security #       Number of Children         Occupation       Employer       Spouse's Name       Spouse's Occupation         Spouse's Employer       Spouse's Health Status       Spouse's Occupation         Spouse's Employer       Spouse's Health Status       Emergency Contact         Current Complaints       Phone       Phone         Nature of Injury:       Automobile*       Work       Other         Please describe:       Date symptoms appeared       Have you ever had same condition?       Mo         List of other practitioners seen for this injury/condition       Have you ever been under chiropractic care?       No       Yes         If yes, please describe       If yes, when?       If yes, please describe       If yes, please describe         Ist of other practitioners seen for this injury/condition       Have you ever been under chiropractic care?       No       Yes         If yes, please describe       If yes, none of company       *If on outo accident, please provide:       *If on outo accident, please provide:	First Name	Last Name	Date	Email*	
Address City State Zip   Telephone (Work) (home) Referred By   Age Birth Date Social Security # Number of Children   Occupation Employer Spouse's Name Spouse's Occupation   Spouse's Employer Spouse's Health Status Emergency Contact   Emergency Contact Phone     Outrent Complaints   Nature of Injury: Automobile*   Work Other   Please describe:    Date if Injury Date symptoms appeared   Have you ever had same condition? No   Have you ever been under chiropractic care? No   Yes If yes, please describe   Insurance Information Name of party responsible for payment Yes Yes Yes Name of company Name Contact Person Phone Dote company Name Claim #	* Your email	will NOT be shared with any	 3d parties, and is use	ed for occasional office an	nouncements and promotions.
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Occupation Employer   Marital Status Spouse's Name   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 Yes   If yes, please describe   Insurance Information   Nome of party responsible for payment Phone Do you have health insurance? No Yes Name of contact Person Phone Phone <	Telephone (Work)	(hor	ne)	Referred B	
Marital Status Spouse's Name   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   No   Name of party responsible for payment   Do you have health insurance?   No   Yes   Insurance Company Name   Contact Person	Age Birth Date	Socio	xl Security #	Number of C	hildren
Spouse's Employer   Emergency Contact     Phone     Current Complaints     Nature of Injury:   Automobile*   Work   Please describe:      Date if Injury   Date symptoms appeared   Have you ever had same condition?   No   Yes   If yes, please describe     If yes, please describe     Insurance Information     Name of party responsible for payment   Phone   Do you have health insurance?   Name of company Name   Phone:   Claim #	Occupation		Employer		
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, vhen?     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   Do you have health insurance?   No   Yes   Insurance Company Name   Phone:   Claim #	Marital Status	Spouse's Name	L	Spouse's Occupati	on
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If yes, please describe  Insurance Information  Name of party responsible for payment  Do you have health insurance? No Yes Name of company  * If an auto accident, please provide: Insurance Company Name  Contact Person  Phone:  Claim #					
Name of party responsible for payment       Phone         Do you have health insurance?       O No O Yes       Name of company         * If an auto accident, please provide:       Insurance Company Name       Contact Person         Phone:       Claim #       Claim #			U Tes		
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* If an auto accident, please provide:         Insurance Company Name       Contact Person         Phone:       Claim #	Name of party responsible	for payment		Phone	
Insurance Company Name Contact Person Contact Person			ne of company		
Phone: Claim #	-		Contact P	erson	
	· · ·		Conderre		
Signatures	Signatures				
Name of the insured	Name of the insured				
I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier		I understand and agree that	health/accident insurar	nce policies are an arrangeme	nt 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		and myself. I understand an	d agree that all services	s rendered to me and charged	are my personal
professional services rendered to me will be immediately due and payable.		professional services rendered	ed to me will be immedi	iately due and payable.	
Patient's signature Date Spouse's or guardian's signature Date	Patient's signature	- signatura		Date	
Spouse's or guardian's signature Date	spouse's or guardian	s signature		Date	

Medical History			
Have you been treated for any condition	s in the last year? O No O Yes		
If yes, please describe			
Date of last physical exam	Is there a chance that you are pregnant? O No O Yes		
Have you had X-rays taken? O No O 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).			
	contentity takes (riedse list for what containons, 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?	000000	

## Family History Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	O No O Yes
Do your symptoms interfere with daily life?	O No O Yes
Does pain wake you up at night?	O No O Yes
Are your symptoms worse during certain times of the day?	O No O Yes
Do changes in weather affect your symptoms?	O No O Yes
Do you wear orthotics?	O No O Yes
Do you take vitamin supplements?	O No O Yes
What activities aggravate your symptoms?	

Habits	None	Light	Moderate	Heavy
Alcohol	0	0	0	0
Coffee	ΙŎ	I X	Ň	ň
Tobacco	ΙŎ	I N	Ň	ň
Drugs	ΙŎ	δ	Ŏ	Ŏ
Exercise	ΙÕ	Ō	Ŏ	Õ
Sleep	ΙŌ	ΙŌ	Ō	Ō
Appetite				0
Soft Drinks			O I	Q
Water	I Q	I Q	Q	Q
Salty Foods	I Q	I Q	Q	Q
Sugary Foods	I Q	I Q	Q	Q
Artificial Sweeteners			0	0

Have you ever suffered from:	
Alcoholism	Please use the following letters to indicate TYPE and
	LOCATION of the symptoms you currently are experiencing.
	A=Ache O=Other
Arteriosclerosis	
Arthritis	B=Burning P=Pins & Needles
Asthma	N=Numbness S=Stabbing
Back Pain	
Breast Lump	
Bronchitis	
Bruise Easily	
Chest Pain/Conditions	
Cold Extremities	
Constipation	
Cramps	
Diabetes	
Digestion Problems	
Dizziness	
Ears Ring	
Eye Pain or Difficulties	
Fatigue	
Frequent Urination	
Headache	
High Blood Pressure	
Hot Flashes	
Irregular Heart Beat	
Irregular Cycle	
Kidney Infection	
Kidney Stones	
Loss of memory	
Loss of balance	
Loss of smell	
Loss of taste	
Lumps In Breast	
Neck Pain or Stiffness	
Pacemaker	
Poor Posture	
Prostate Trouble	
Shortness of breath	
Sinus Infection	
Sleep problems or Insomnia	
Spinal Curvatures	
Swelling of ankles	
Swollen Joints	
Varicose Veins	
Venereal Disease	
Other:	