



# New Patient Health History Form

In order 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

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Email (For our office use only) \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
 Age \_\_\_\_\_ Sex \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
 Emergency Contact/Relationship \_\_\_\_\_  
 Who May We Thank For Referring You? \_\_\_\_\_  
 Previous Chiropractic or Physical Therapy Care?  Yes  No  
 If yes, please describe \_\_\_\_\_

## Insurance Information

Health Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
 Subscriber \_\_\_\_\_ Subscribers Employer \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 Auto Claim Ins. Co. \_\_\_\_\_ Contact Person \_\_\_\_\_  
 Phone \_\_\_\_\_ Claim # \_\_\_\_\_  
 Name of the insured \_\_\_\_\_

I understand and agree that the 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 \_\_\_\_\_  
 Spouse's or Guardian's Signature \_\_\_\_\_

## Current Complaints

Nature of Injury: Automobile  Work  Other  \_\_\_\_\_  
 Please Describe \_\_\_\_\_  
 \_\_\_\_\_  
 Date of Injury \_\_\_\_\_ Date Symptoms Appeared \_\_\_\_\_  
 Please describe complaint and how it began \_\_\_\_\_  
 \_\_\_\_\_  
 When did this begin? \_\_\_\_\_  
 What makes it feel better? \_\_\_\_\_  
 What makes it feel worse? \_\_\_\_\_



**Have you ever suffered from:** **Date:** \_\_\_\_\_

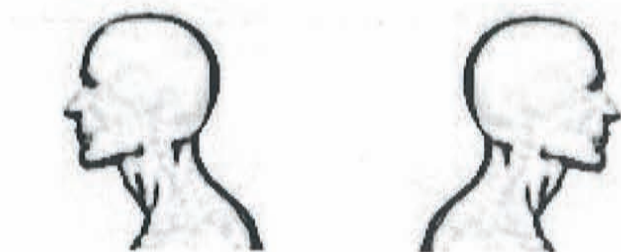
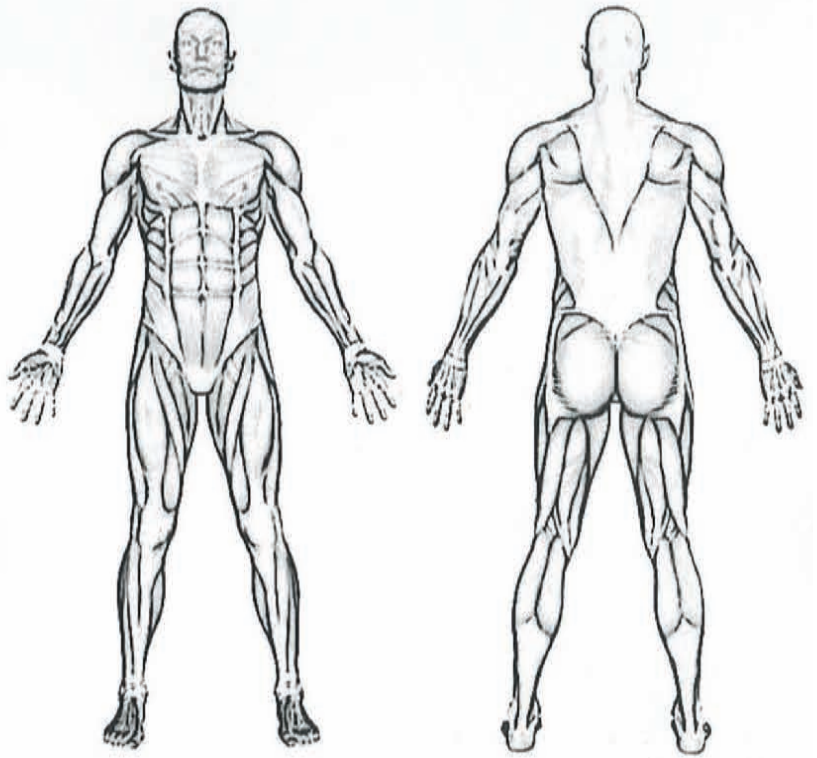
- Alcoholism \_\_\_\_\_
- Allergies \_\_\_\_\_
- Anemia \_\_\_\_\_
- Arteriosclerosis \_\_\_\_\_
- Arthritis \_\_\_\_\_
- Back Pain \_\_\_\_\_
- Breast Lump \_\_\_\_\_
- Bronchitis \_\_\_\_\_
- Bruise Easily \_\_\_\_\_
- Cancer \_\_\_\_\_
- Chest Pain/Conditions \_\_\_\_\_
- Cold Extremities \_\_\_\_\_
- Constipation \_\_\_\_\_
- Cramps \_\_\_\_\_
- Depression \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Digestion Problems \_\_\_\_\_
- Dizziness \_\_\_\_\_
- Ears Ring \_\_\_\_\_
- Excessive Menstruation \_\_\_\_\_
- Eye Pain/Difficulties \_\_\_\_\_
- Fatigue \_\_\_\_\_
- Frequent Urination \_\_\_\_\_
- Headache \_\_\_\_\_
- Hemorrhoids \_\_\_\_\_
- 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 \_\_\_\_\_
- Neck Pain or Stiffness \_\_\_\_\_
- Nervousness \_\_\_\_\_
- Nosebleeds \_\_\_\_\_
- Pacemaker \_\_\_\_\_
- Polio \_\_\_\_\_
- Poor Posture \_\_\_\_\_
- Prostate Trouble \_\_\_\_\_
- Sciatica \_\_\_\_\_
- Shortness of Breath \_\_\_\_\_
- Sinus Infection \_\_\_\_\_
- Sleep Problems/Insomnia \_\_\_\_\_
- Spinal Curvatures \_\_\_\_\_
- Stroke \_\_\_\_\_
- Swelling of Ankles \_\_\_\_\_
- Swollen Joints \_\_\_\_\_
- Thyroid Condition \_\_\_\_\_
- Tuberculosis \_\_\_\_\_
- Ulcers \_\_\_\_\_
- Varicose Veins \_\_\_\_\_
- Venereal Disease \_\_\_\_\_
- Other \_\_\_\_\_

**Current Complaints (Continued)**

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

A=Ache  
B=Burning  
N=Numbness

O=Other  
P=Pins & Needles  
S=Stabbing



Pain Level 0 1 2 3 4 5 6 7 8 9 10  
No Pain Severe Pain

Patient's Signature \_\_\_\_\_