Fischer Health & Rehab
413 King George Road, Suite 205 • Basking Ridge, NJ 07920 • Phone: 908.903.1901 • Fax: 908.903.1902

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? _____

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Current Complaints (Continued)

Is it traveling anywhere (down legs, etc?) _____

How often is it present? Constant (81-100%) Frequent (51-80%) Occasional (26-51%) Mild (25% or less)

Have you been treated for this condition with another Doctor or Therapist? ☐ Yes ☐ No

If so whom? ☐ MD ☐ Chiropractor ☐ Physical Therapist ☐ Other

What treatments have you received? _____

How much is this effecting your daily activities?

0 1 2 3 4 5 6 7 8 9 10

Not at all Severely

Medical History

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

If yes, please describe _____

Date of last exam _____ Is there a chance you are pregnant? ☐ Yes ☐ No

Major Surgery/Operations _____

Major Accidents or Falls _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc.) _____

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosages, and frequency).

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits:

	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

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

What activities aggravate your symptoms? _____

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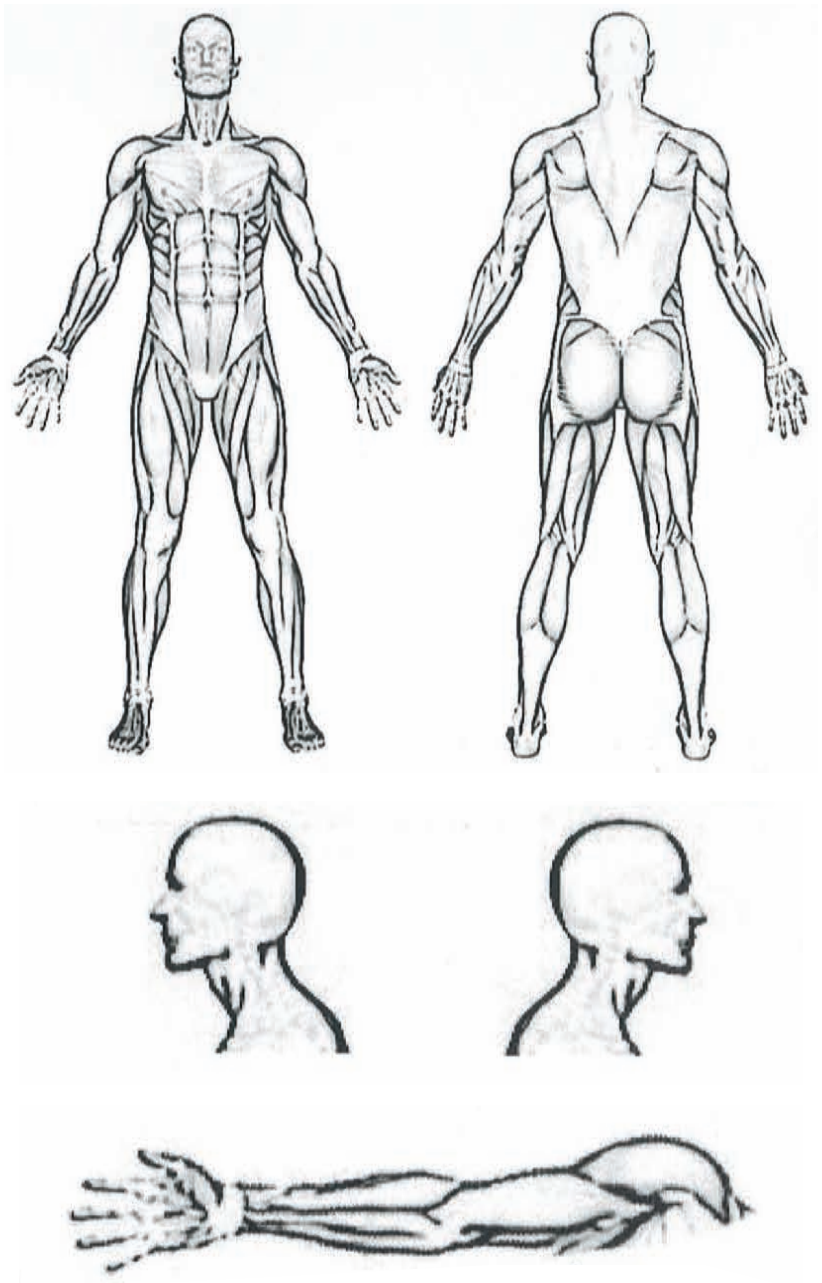
Have you ever suffered from:		Date:
Alcoholism	☐	
Allergies	☐	
Anemia	☐	
Arteriosclerosis	☐	
Arthritis	☐	
Back Pain	☐	
Breast Lump	☐	
Bronchitis	☐	
Bruise Easily	☐	
Cancer	☐	
Chest Pain/Conditions	☐	
Cold Extremities	☐	
Constipation	☐	
Cramps	☐	
Depression	☐	
Diabetes	☐	
Digestion Problems	☐	
Dizziness	☐	
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 _____