

New Patient Health History Form

Patient information	
Name _____	Nickname (if other than name) _____
Email _____	Referred By _____

Billing Address	
Address _____	City _____ State _____ Zip _____
Phone (cell) _____	(home) _____
Age _____	Birth date _____ Social Security # _____
Occupation _____	Employer _____
Marital Status _____	Number of Children _____
Emergency Contact _____	Phone _____

Reason for your Visit	
What is your visit related to:	
Work Comp _____	Auto _____ Wellness _____ Other _____
If other, please describe:	

Date symptoms appeared _____	
Have you ever had the same condition? No _____ Yes _____	
If yes, when _____	
List other practitioners you've seen for this	

Have you ever been under chiropractic care before this visit No _____ Yes _____	
Last date of service: _____	
Would you be interested in a nutritional consultation? No _____ Yes _____	
Would you be interested in orthotics? No _____ Yes _____	

Insurance Information	
Will you be using your health insurance? No _____ Yes _____	
Name of company _____	
Policy Holders Name _____	Policy Holders D.O.B. _____

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

Medical History
Have you been treated for any condition in the last year? No ___ Yes ___
If yes, please describe _____
Is there a chance you are pregnant? No ___ Yes ___
Have you had x-rays taken? No ___ Yes ___ If yes, Where _____
Please list any medications (including vitamins/herbs) that you are taking.

List any known allergies you have to medications. If no allergies, check here _____

Past Injuries	If yes, Briefly explain	
Broken bones?	No ___ Yes ___	_____
Been Hospitalized?	No ___ Yes ___	_____
Been in an auto accident?	No ___ Yes ___	_____
Had Sprains/Strains?	No ___ Yes ___	_____
Been struck unconscious?	No ___ Yes ___	_____
Had Surgery?	No ___ Yes ___	_____

Habits	None	Moderate	Heavy		None	Moderate	Heavy
Sleep	___	___	___	Appetite	___	___	___
Alcohol	___	___	___	Soft Drinks	___	___	___
Coffee	___	___	___	Water	___	___	___
Tobacco	___	___	___	Salty Foods	___	___	___
Exercise	___	___	___	Sugary Foods	___	___	___

Have you ever suffered from:

- Alcoholism
- Allergies
- Anemia
- Arthritis
- Back Pain
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pains
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ringing
- Excessive Menstruation
- Eye Pain/ Difficulties
- Fatigue
- Frequent Urination
- Headaches
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Stones
- Loss of Balance
- Loss of Memory
- Neck pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Prostate Trouble
- Sciatica
- Shortness of Breath
- Sinus Infections
- Sleep Problems
- Stroke
- Venereal Disease

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

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

