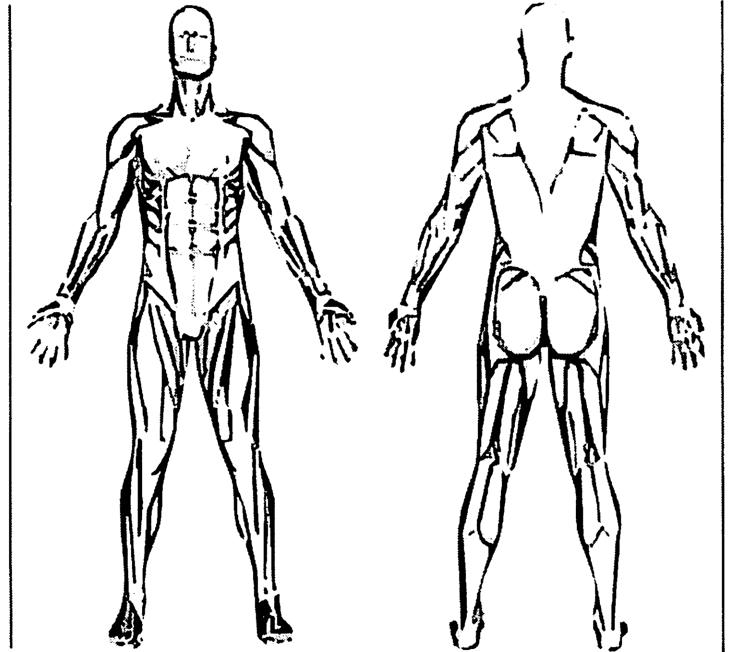
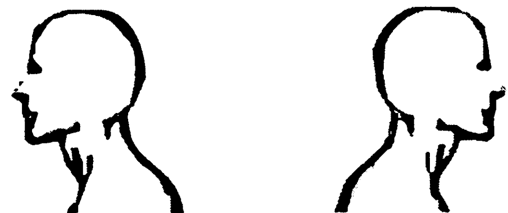
Have you ever suffered from:
____ Alcoholism
____ Allergies
____ Anemia
____ Arthritis
____ Back Pain
____ Bronchitis
____ Bruise Easily
____ Cancer
____ Chest Pains
____ Cold Extremities
____ Constipation
____ Cramps
____ Depression
____ Diabetes
____ Digestion Problems
____ Dizziness
____ Ears Ringing
____ 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





Current Condition

Question	No	Yes
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

Past Injuries	No	Yes	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

Habits	None	Light	Heavy		None	Light	Heavy
Sleep	____	____	____	Appetite	____	____	____
Alcohol	____	____	____	Soft Drinks	____	____	____
Coffee	____	____	____	Water	____	____	____
Tobacco	____	____	____	Salty Foods	____	____	____
Exercise	____	____	____	Sugary Foods	____	____	____

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 ____________________
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. __________