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.

Patient Data

First Name ______ Last Name ______ Date ______ Email* ______

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address ______ City ______ State ______ Zip ______

Telephone (Work) ______ (home) ______ Referred By ______

Age ______ Birth Date ______ Social Security # ______ Number of Children ______

Occupation ______ Employer ______

Marital Status ______ Spouse's Name ______ Spouse's Occupation ______

Spouse's Employer ______ Spouse's Health Status ______

Emergency Contact ______ Phone ______

Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe: ______

Date of 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

Name of party responsible for payment ______ Phone ______

Do you have health insurance? ○ No ○ Yes Name of company ______

*** If an auto accident, please provide:**

Insurance Company Name ______ Contact Person ______

Phone: ______ Claim # ______

Signatures

Name of the insured ______

I understand and agree that 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 ______ Date ______

Spouse’s or guardian’s signature ______ Date ______

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Medical History

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

If yes, please describe

Date of last physical exam   Is there a chance that you are pregnant? ○ No ○ Yes

Have you had X-rays taken? ○ No ○ Yes   If Yes, where?

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

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, 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?	○	○	

Family History

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

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?

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

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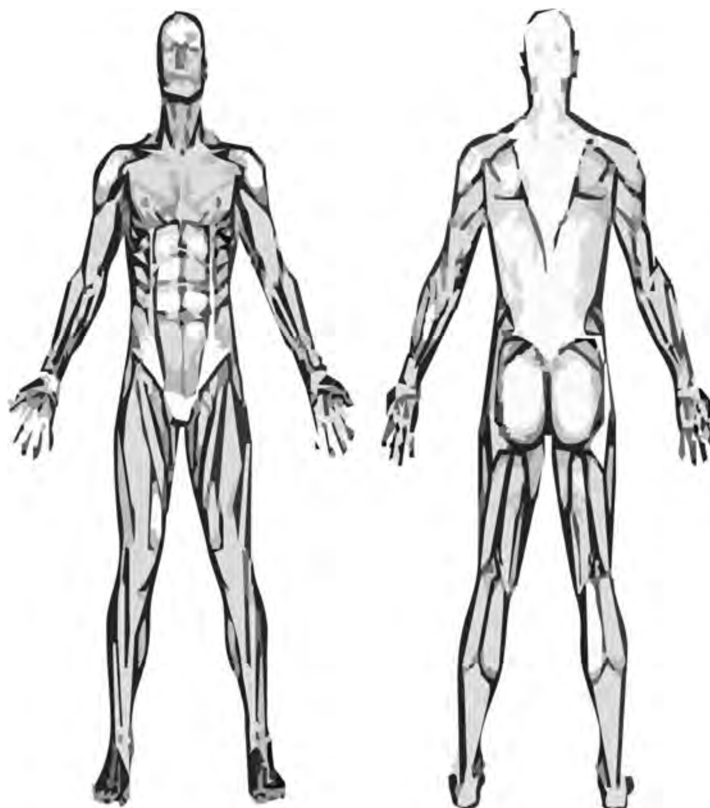
Have you ever suffered from:	
☐ Alcoholism ☐ Allergies ☐ Anemia ☐ Arteriosclerosis ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Breast Lump ☐ Bronchitis ☐ Bruise Easily ☐ Cancer ☐ Chest Pain/Conditions ☐ Cold Extremities ☐ Constipation ☐ Cramps ☐ Depression ☐ Diabetes ☐ Digestion Problems ☐ Dizziness ☐ Ears Ring ☐ Excessive Menstruation ☐ Eye Pain or 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 ☐ Lumps In Breast ☐ Neck Pain or Stiffness ☐ Nervousness ☐ Nosebleeds ☐ Pacemaker ☐ Polio ☐ Poor Posture ☐ Prostate Trouble ☐ Sciatica ☐ Shortness of breath ☐ Sinus Infection ☐ Sleep problems or Insomnia ☐ Spinal Curvatures ☐ Stroke ☐ Swelling of ankles ☐ Swollen Joints ☐ Thyroid Condition ☐ Tuberculosis ☐ Ulcers ☐ Varicose Veins ☐ Venereal Disease ☐ Other: ______	Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing. **A**=Ache **O**=Other **B**=Burning **P**=Pins & Needles **N**=Numbness **S**=Stabbing 

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Date: ______________
Patient # ____________

Automobile Accident History

Last ______________ First ______________ Middle Initial ______ Birth Date __________ Age ______

Address ______________________ City ______________ ST ______ Zip ______________

Phone (H) ______________ (W) ______________ (C) ______________

Email ______________________ May we send you our online newsletter? ☐ yes ☐ no

Occupation ______________ Employer ______________

Spouse's Name ______________ Business/Employer ______________ Spouse Phone: ______________

Who is your primary care physician? ______________ Address: ______________

Phone: ______________ Date of last physical/exam? ______________ With Whom? ______________

Date of Accident: ______________ Time of Accident: __________ am / pm ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark

Road conditions at the time of the accident: ☐ Wet ☐ Dry ☐ Snow ☐ Ice ☐ Other ______________

Was the accident on the job? ☐ Yes ☐ No Where you in a company vehicle? ☐ Yes ☐ No

Where were you seated in the vehicle? ☐ Driver ☐ Passenger ☐ Rear-seat ☐ Other ______________

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? ☐ Aware ☐ Surprise

Did you lose consciousness upon impact? ☐ Yes ☐ No Did you experience a flash of light or explosion in your head? ☐ Yes ☐ No

Did the police come to the accident scene? ☐ Yes ☐ No Is there a police report? ☐ Yes ☐ No

Did you go to the hospital? ☐ Yes ☐ No When? ☐ Immediately ☐ ___hours later ☐ ___days later Which hospital? ______________

How did you get to the hospital? ______________ How long did you stay in the hospital? ______________

What did the hospital do for your injuries? (collars, splints, x-rays, medication etc.) ______________

What areas were x-rayed? ______________ What was their diagnosis? ______________

What did they recommend for follow-up care? ______________

Was any other doctor consulted after your accident? ☐ Yes ☐ No If yes, please complete information below.

Dr. ______________ Specialty? ______________ Date first seen: ______________

Type of treatment: ______________ Treatment frequency: ______________ How long did you treat? __________

Dr. ______________ Specialty? ______________ Date first seen: ______________

Type of treatment: ______________ Treatment frequency: ______________ How long did you treat? __________

Were you wearing a seatbelt? ☐ Yes ☐ No If yes, did you receive any injury or bruise from the seat belt? ☐ Yes ☐ No

Did your head hit the head rest during the accident? ☐ Yes ☐ No If adjustable, was the position of the head rest altered? ☐ Yes ☐ No

Was the seat adjustment altered by the accident? ☐ Yes ☐ No Was the seat broken by the accident? ☐ Yes ☐ No

Did the air-bag deploy? ☐ Yes ☐ No If yes, did it strike you? ☐ Yes ☐ No If yes, where? ______________

Which way was your head pointing at the point of impact? ☐ Straight ☐ Right ☐ Left Body? ☐ Straight ☐ Right ☐ Left

Where were your hands? ☐ One on the wheel ☐ Both on the wheel ☐ Not Applicable

Were you wearing a hat or glasses at the time of impact? ☐ Yes ☐ No If so, were they still on after the accident? ☐ Yes ☐ No

YOUR CAR

List the year, make and model of the car you were in: YEAR: __________ MAKE: ________________ MODEL: __________________

Was your car stopped at the time of impact? ☐Yes ☐No If yes, was the driver's foot on the brake? ☐Yes ☐No If no, estimate the speed of the vehicle you were in: __________mph

If your vehicle was moving at the time of impact, was it: ☐Slowing down ☐Gaining speed ☐Steady speed

THE OTHER CAR

List the year, make and model of the other car : YEAR: __________ MAKE: ________________ MODEL: __________________

Was the other car moving at the time of impact? ☐Yes ☐No If yes, what was the approximate speed of the vehicle : __________mph

At the time of impact, was the other car: ☐Slowing down ☐Gaining speed ☐Steady speed

Please describe, to the best of your knowledge, what happened during this accident.

____

____

____

____

____

____

You may draw the accident here

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in: ______________________ **Name of their auto insurance:** ______________

Policy #: ______________________ **Claim #:** ______________________

Auto insurance phone #: ______________________ **Name of insurance adjuster:** ______________________

Driver of the other vehicle: ______________________ **Name of their auto insurance:** ______________

Policy #: ______________________ **Claim#:** ______________________

Auto insurance phone #: ______________________ **Name of insurance adjuster:** ______________________

At the time of the accident, did you become or experience any of the following? ☐Confused ☐Disoriented ☐Light headed ☐Dizzy ☐Nauseated ☐Blurred vision ☐Ringing/Buzzing in ears ☐Loss of balance ☐Other: ______________________

Do you still have any of those symptoms? ☐Yes ☐No **If yes, which ones?** ______________________

Check symptoms you have noticed since the accident.

☐ Headaches/Migraines	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Midback Pain
☐ Low Back Pain	☐ Depression	☐ Buzzing In Ears	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Loss of Memory	☐ Cold Hands/Feet	☐ Numbness/Tingling
☐ Loss of Smell	☐ Irritability	☐ Digestive Problems	☐ Joint Pain/Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Loss of Balance	☐ Chest Pain	☐ Light Bothers Eyes
☐ Fever	☐ Nervousness	☐ Vision Problems	☐ Urinary Problems	☐ Sleeping Problems
☐ Paralysis	☐ Tension	☐ Fainting	☐ Pins/Needles Feeling	☐ Stomach Upset
☐ Difficulty Swallowing	☐ Sciatica	☐ Sinus Pain	☐ Sore Muscles	☐ Head Feels To Heavy
☐ Other:				

Activities of Daily Living Assessment

Rate your current difficulties by placing the appropriate number in the box.

If an activity does not cause pain or if pain does not effect an activity, leave box blank.

[1] This activity causes some pain, but it is of minor annoyance.

[2] This activity causes a significant amount of pain.

[3] I cannot perform this activity due to pain and disability.

Self Care and Personal Hygiene

- [ ] bathing
- [ ] brushing teeth
- [ ] putting on shoes
- [ ] doing laundry
- [ ] grooming hair
- [ ] making bed
- [ ] putting on pants
- [ ] doing dishes
- [ ] washing face
- [ ] putting on shirt
- [ ] cooking
- [ ] taking out trash
- [ ] going to bathroom or sitting on toilet

Physical Activities

- [ ] standing
- [ ] walking
- [ ] reaching
- [ ] bending right
- [ ] twisting right
- [ ] sitting
- [ ] squatting
- [ ] bending
- [ ] bending left
- [ ] twisting left
- [ ] reclining
- [ ] bending back
- [ ] kneeling
- [ ] looking left
- [ ] looking right

Functional Activities

- [ ] carrying small objects
- [ ] lifting weight off table
- [ ] push/pull standing
- [ ] carrying large objects
- [ ] climbing stairs/incline
- [ ] exercising upper body
- [ ] exercising lower body
- [ ] carrying purse/case
- [ ] lifting objects off floor
- [ ] push/pull seated

Social & Recreational Activities

- [ ] jogging
- [ ] biking
- [ ] swimming
- [ ] dancing
- [ ] golfing
- [ ] bowling
- [ ] hunting
- [ ] fishing
- [ ] gardening
- [ ] basketball
- [ ] soccer
- [ ] hockey
- [ ] competitive sports

Difficulties with Travel

- [ ] driving in car
- [ ] riding as passenger
- [ ] entering and exiting vehicle
- [ ] driving for long periods of time
- [ ] riding as passenger for long period of time

Other Activities

- [ ] concentrating
- [ ] studying
- [ ] listening
- [ ] reading
- [ ] writing
- [ ] using computer
- [ ] sleeping
- [ ] sexual relation

Patient Name: Date: Score: