# 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 3rd parties, and is used for occasional office announcements.

Language: English Spanish Other

Race/Ethnicity: White Black/African American Hispanic Asian Other Decline to Answer

## Contact Information

Address City State Zip

Telephone (home) (work) Referred By Birthdate age

Social Security # # Children Occupation Employer

Marital Status Spouses Name Spouse's Occupation

## 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 Doctors seen for this condition/injury

Have you ever been under Chiropractic Care? 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 Do you wear orthotics? No Yes

What activities aggravate your symptoms?

Do you have Clicking in your neck and/or back No Yes Is your condition getting worse? No Yes

## 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 any chance that you are pregnant? No Yes

Have you had x-rays or MRI's taken? No Yes If yes, when?

Do you smoke? Never Former Smoker Current/Everyday Smoker Current Some Day(s) Smoker

Height Weight Blood Pressure from most recent exam

**Medications:** What medications are you currently taking? Please include Name, Dosage, Frequency and Managing/Prescribing Doctor

**Allergies:** Medication Food Environmental None If yes, plist list the type of allergy

Have you ever been diagnosed with hypertension? No Yes If yes, who is managing Doctor?

Have you ever been diagnosed with diabetes? No Yes If yes, who is managing Doctor?

Have you ever had any work related injuries? No Yes

Have you ever been in any motor vehicle accidents (>5 mph)? No Yes

Do you sleep on your side your back your stomach What type of Mattress do you have?

| Family History | Father's Side | Mother's Side |
|---|---|---|
| Heart disease | Yes | Yes |
| Cancer | Yes | Yes |
| Diabetes | Yes | Yes |

| Have you ever suffered from or experienced any of the following? | | |
|---|---|---|
| Alcoholism | Numbness in Toes | Loss of Balance |
| Headaches | Numbness in Fingers | Ringing in Ears |
| Neck Pain | Fatigue | Fainting |
| Sleeping Problems | Depression | Loss of Smell |
| Back Pain | Loss of Memory | Loss of Taste |
| Nervousness | Constipation | Cold Feet |
| Chest Pain | Shortness of Breath | Cold Hands |
| Pins/Needles in Legs | Dizziness | Irritability |
| Pins/Needles in Arms | Stiff Neck | Weight Issues |

**I choose to decline receipt of my clinical summary after every visit** (These summaries are often blank as a result of the nature and frequency of Chiropractic care)

Patient Signature: ______________________________________