

Date: _____ Patient Name: _____ Clinic ID: _____

New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form.

All information is strictly CONFIDENTIAL.

Date _____
Title _____ First Name _____ MI _____ Last Name _____
Preferred Name / Nickname _____
Address _____
City _____ State _____ Zip Code _____
Phone: Home _____ Work _____ Cell _____
Birth Date (MM/DD/YY) _____ Age _____ Email _____
Social Security # _____ Status: Single Married Other _____
Employment status: Employed Student Other _____

Spouse Information:

First Name _____ MI _____ Last Name _____
Phone: Home _____ Work _____ Cell _____
Is your Spouse a patient in our Office? Yes No

Work Information:

Employer Name _____
Address _____
City _____ State _____ Zip Code _____
Describe your job: _____
Is it OK to call you at work? Yes No

Emergency Contact:

Emergency Contact _____ Phone _____
Relationship _____

How did you hear about our Clinic? Or who referred you?

family member attorney internet website sign on building
 friend Yellow Pages radio brochure
 physician newspaper add health class coupon
 employer Other _____

If you selected "family member", "friend" or "physician" please provide their name below:

Date: _____ Patient Name: _____ Clinic ID: _____

Is your current problem a: Work Injury Automobile Injury Other _____

Are you currently taking any medication or nutritional supplements? (If yes, please describe)

No Yes → List: _____

In the Past have you suffered: (please explain, give details)

Sports related injuries _____

Sprain/strain injuries _____

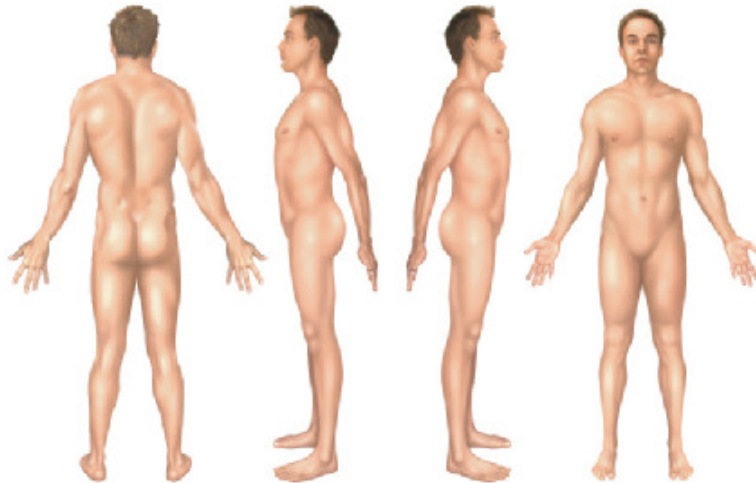
Auto accidents _____

Please mark the location and type the letter that better describes your symptoms:

A = ache
S = sharp / stabbing

P = pins & needles
N = numbness

B = burning
O = other



How are your symptoms changing? Getting better Not changing Getting worse

During the past 4 weeks, how much has the pain interfered with your normal work?

Not at all a little bit moderately quite a bit extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

All the time most of the time some of the time a little of the time none of the time

Who have you seen for your symptoms?

No one Other Chiropractor Medical Doctor Physical Therapist Other _____

What treatments did you receive for your symptoms?

Adjustments Physical Therapy Medication Surgery Other _____

When did you receive this treatment?

In the last month 2-3 mo ago 3-6 mo ago 6 mo-1 yr ago 1-2 yrs ago 2-5 yrs ago 5-10 yrs ago

What tests have you had for your symptoms? X-rays MRI CT Scan Other _____

When were these tests done?

In the last month 2-3 mo ago 3-6 mo ago 6 mo-1 yr ago 1-2 yrs ago 2-5 yrs ago 5-10 yrs ago

Have you had similar symptoms in the past? Yes No

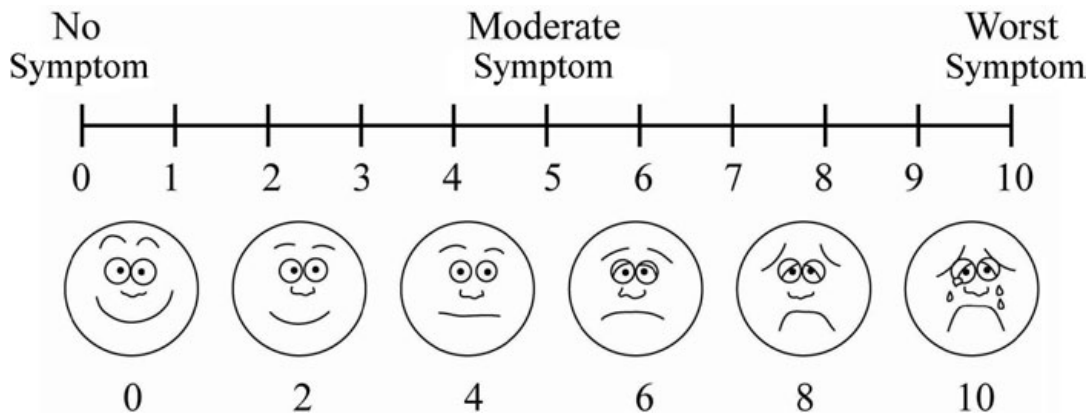
If you have received treatment in the past for the same or similar symptoms, who did you see?

This Office Other Chiropractor Medical Doctor Physical Therapist Other _____

In order to provide you with the best care, please describe each one of your complaints on a different form.

1. Please describe your problem:

My symptom intensity is: _____



Date of injury or when the symptoms appeared _____

Mark all that apply to your condition:

1. You have symptoms: less than 26% 26-50% 51-75% 76-100% of the day
2. Is it? worse in the morning worse at midday worse at night same through the day
3. Your pain is:

<input type="checkbox"/> Dull	<input type="checkbox"/> Sharp	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Burning	<input type="checkbox"/> Deep	<input type="checkbox"/> Aching
<input type="checkbox"/> Tingling	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Cramping	<input type="checkbox"/> Numbness	<input type="checkbox"/> Radiating	<input type="checkbox"/> Other _____
4. Do your symptoms radiate? down your arms down your legs other _____
5. What makes you feel worse?

<input type="checkbox"/> sitting	<input type="checkbox"/> standing	<input type="checkbox"/> walking	<input type="checkbox"/> bending	<input type="checkbox"/> stooping	<input type="checkbox"/> lifting
<input type="checkbox"/> sleeping	<input type="checkbox"/> sneezing	<input type="checkbox"/> coughing	<input type="checkbox"/> straining	<input type="checkbox"/> reaching	<input type="checkbox"/> twisting
<input type="checkbox"/> looking up	<input type="checkbox"/> looking down	<input type="checkbox"/> movement	<input type="checkbox"/> rest	<input type="checkbox"/> lying	<input type="checkbox"/> driving
<input type="checkbox"/> typing	<input type="checkbox"/> scooping	<input type="checkbox"/> household chores	<input type="checkbox"/> exercise	<input type="checkbox"/> stair stepping	
<input type="checkbox"/> other _____					
6. What makes you feel better?

<input type="checkbox"/> sitting	<input type="checkbox"/> standing	<input type="checkbox"/> lying	<input type="checkbox"/> knees bent up	<input type="checkbox"/> support
<input type="checkbox"/> no movement	<input type="checkbox"/> movement	<input type="checkbox"/> heat	<input type="checkbox"/> ice	<input type="checkbox"/> analgesic topical
<input type="checkbox"/> ibuprofen	<input type="checkbox"/> medication	<input type="checkbox"/> rest	<input type="checkbox"/> stretching/exercise	<input type="checkbox"/> adjustments
<input type="checkbox"/> other _____				

Have you ever suffered from: (Mark all that apply)

Medical Conditions:

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric illness	Skin Disorder	Stroke

Surgeries:

Appendectomy	Cardiovascular procedure	Cervical disc procedure	Hysterectomy
Joint replacement	Laminectomies	Other (Describe below)	Radical prostatectomy
Transurethral prostate surgery		_____	

Allergies:

Eggs	Fish and Shellfish	Milk or Lactose	Peanut
Soy	Sulfites	Wheat/Gluten	Medications

Social History:

caffeine used occasionally	caffeine used often	chew tobacco occasionally	chew tobacco often
drink alcohol occasionally	drink alcohol often	exercise not at all	exercise occasionally
exercise often	experience stress occasionally	experience stress often	smoke 1 pack or less/day
smoke > 1 pack/day	wear seatbelts always	wear seatbelts never	wear seatbelts usually

Family History:

arthritis (parent)	arthritis (sibling)	cancer (parent)	cancer (sibling)
cholesterol (parent)	cholesterol (sibling)	diabetes (parent)	diabetes (sibling)
heart problems (parent)	heart problems (sibling)	high blood pressure (parent)	high blood pressure (sibling)
psychiatric (parent)	psychiatric (sibling)	stroke (parent)	stroke (sibling)
thyroid (parent)	thyroid (sibling)		

Substance Use:

Alcohol (past)	Alcohol (present)	Amphetamines (past)	Amphetamines (present)
Barbiturates (past)	Barbiturates (present)	Cocaine (past)	Cocaine (present)
Crystal Meth	Heroin (past)	Heroin (present)	Marijuana (past)
Marijuana (present)			

Male Children: # _____

under 6 years	under 10 years	under 19 years
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Female Children: # _____

under 6 years	under 10 years	under 19 years
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Occupational Activities:

retired	administration	business owner	clerical/secretarial
computer user	construction	daycare/childcare	executive/legal
farmer	food service industry	healthcare	heavy equipment operator
heavy manual labor	home services	household	light manual labor
manufacturing	medium manual labor	military	police/fire
professional services	retail worker	teacher	truck driver

Recreational Activities:

backpacking	biking	boating	bowling
exercise machines	football	golf	racket ball
running	skiing	soccer	swimming
tennis	walking	weight lifting	

Have you had trouble with any of the following: (Mark all that apply)

Cardiovascular:

None =
 Present Past No

- Poor Circulation
- High Blood Pressure
- Aortic Aneurysm
- Heart Disease
- Vascular Disease
- Heart Attack
- Chest Pain
- High Cholesterol
- Pace Maker
- Jaw Pain
- Irregular Heartbeat
- Swelling of Legs

Genitourinary:

None =
 Present Past No

- Kidney Disease
- Lower Side Pain
- Burning Urination
- Frequent Urination
- Blood in Urine
- Kidney Stone

Hematologic/Lymphatic:

None =
 Present Past No

- Hepatitis
- Blood Clots
- Cancer
- Easy Bruising
- Easy Bleeding
- Fever/Chills/Sweats
- Varicose Veins

Endocrine:

None =
 Present Past No

- Thyroid Disease
- Diabetes
- Hair Loss
- Menopausal
- Menstrual Problems

Respiratory:

None =
 Present Past No

- Asthma
- Tuberculosis
- Shortness of Breath
- Emphysema
- Cold/Flu
- Cough/Wheezing

Ears/Nose/Throat:

None =
 Present Past No

- Dizziness
- Hearing Loss
- Sinus Infection
- Nosebleed
- Sore Throat
- Difficulty Swallowing
- Bleeding Gums

Eyes:

None =
 Present Past No

- Glaucoma
- Double Vision
- Blurred Vision
- Macular Degeneration

Integumentary:

None:
 Present Past No

- Skin Ulcers
- Skin Disease
- Eczema
- Psoriasis
- Rashes

Allergic/Immunologic:

None =
 Present Past No

- Hives
- Immune Disorder
- HIV/AIDS
- Allergy Shots
- Cortisone Use
- Food Sensitivities
- Chemical Sensitivities

Psychiatric:

None =
 Present Past No

- Depression
- Anxiety Disorder
- Unusual Stress

Gastrointestinal:

None =
 Present Past No

- Gallbladder Problems
- Bowel Problems
- Constipation
- Liver Problems
- Ulcers
- Diarrhea
- Nausea/Vomiting
- Bloody Stools
- Poor Appetite

Musculoskeletal:

None =
 Present Past No

- Gout
- Arthritis
- Joint Stiffness
- Muscle Weakness
- Osteoporosis
- Broken Bones
- Joints Replaced

Neurological:

None =
 Present Past No

- Stroke
- Seizures
- Head Injury
- Brain Aneurysm
- Numbness
- Severe Headaches
- Pinched Nerves
- Parkinson's Disease
- Carpal Tunnel
- Spinning/Balance

Constitutional:

None =
 Present Past No

- Weight Loss/Gain
- Energy Level Problem
- Difficulty Sleeping