

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 _____
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 _____

Emergency contact

Emergency contact _____ Phone _____
Relationship _____

Is it ok to call you at work? Yes No

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

- | | | | |
|----------------------------------------|-------------------------------------------|-------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> family member | <input type="checkbox"/> attorney | <input type="checkbox"/> Internet website | <input type="checkbox"/> health class |
| <input type="checkbox"/> friend | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> billboard | <input type="checkbox"/> brochure |
| <input type="checkbox"/> physician | <input type="checkbox"/> newspaper add | <input type="checkbox"/> TV commercial | <input type="checkbox"/> direct-mail advertisement |
| <input type="checkbox"/> employer | <input type="checkbox"/> sign on building | <input type="checkbox"/> Radio | <input type="checkbox"/> 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 _____

In the Past have you suffered: (please explain)

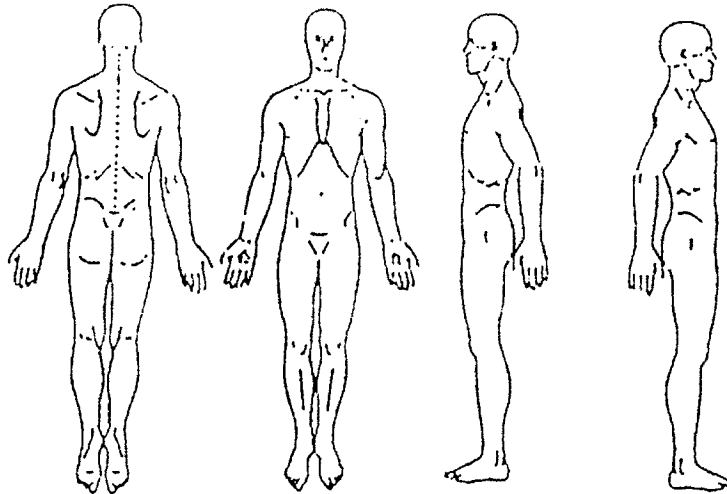
Sport related injuries _____

Sprain/strain injuries _____

Auto accidents _____

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

A = ache P = pins & needles B = burning
S = sharp / stabbing N = numbness O = other



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

During the past 4 weeks, how much has 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

In general would you say your overall health right now is ...?
 Excellent very good good fair poor

Who have you seen for your symptoms?
 No one Other Chiropractor Medical Doctor Physical Therapist Other _____

What treatment 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 year ago 1-2 year ago 2-5 year ago 5-10 year ago

What tests have you have 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 year ago 1-2 year ago 2-5 year ago 5-10 year 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 _____

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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

Circle the intensity: No Pain Mild Pain Moderate Pain Severe Pain Excruciating Pain



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 day

3. Your pain is:

Dull Sharp Throbbing Burning Deep Aching
 Tingling Stabbing Cramping Numbness Radiating 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 _____				

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

Medical Conditions:

- | | | | |
|---------------------------------------|----------------------------------------------|----------------------------------------|----------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke |

Surgeries:

- | | | | |
|---------------------------------------------------------|---------------------------------------------------|--------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical disc procedure | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Laminectomies | <input type="checkbox"/> Other | <input type="checkbox"/> Radical prostatectomy |
| <input type="checkbox"/> Transurethral prostate surgery | | | |

Allergies:

- | | | | |
|-------------------------------|---------------------------------------------|------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanut |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Wheat/Gluten | <input type="checkbox"/> medications |

Social History:

- | | | | |
|-----------------------------------------------------|---------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> caffeine used occasionally | <input type="checkbox"/> caffeine used often | <input type="checkbox"/> chew tobacco occasionally | <input type="checkbox"/> chew tobacco often |
| <input type="checkbox"/> drink alcohol occasionally | <input type="checkbox"/> drink alcohol often | <input type="checkbox"/> exercise not at all | <input type="checkbox"/> exercise occasionally |
| <input type="checkbox"/> exercise often | <input type="checkbox"/> experience stress occasionally | <input type="checkbox"/> experience stress often | <input type="checkbox"/> smoke 1 pack or less / day |
| <input type="checkbox"/> smoke > 1 pack / day | <input type="checkbox"/> wear seatbelts always | <input type="checkbox"/> wear seatbelts never | <input type="checkbox"/> wear seatbelts usually |

Family History:

- | | | | |
|--------------------------------------------------|---------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> arthritis (parent) | <input type="checkbox"/> arthritis (sibling) | <input type="checkbox"/> cancer (parent) | <input type="checkbox"/> cancer (sibling) |
| <input type="checkbox"/> cholesterol (parent) | <input type="checkbox"/> cholesterol (sibling) | <input type="checkbox"/> diabetes (parent) | <input type="checkbox"/> diabetes (sibling) |
| <input type="checkbox"/> heart problems (parent) | <input type="checkbox"/> heart problems (sibling) | <input type="checkbox"/> high blood pressure (parent) | <input type="checkbox"/> high blood pressure (sibling) |
| <input type="checkbox"/> psychiatric (parent) | <input type="checkbox"/> psychiatric (sibling) | <input type="checkbox"/> stroke (parent) | <input type="checkbox"/> stroke (sibling) |
| <input type="checkbox"/> thyroid (parent) | <input type="checkbox"/> thyroid (sibling) | | |

Substance Use:

- | | | | |
|----------------------------------------------|-------------------------------------------------|----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Alcohol (past) | <input type="checkbox"/> Alcohol (present) | <input type="checkbox"/> Amphetamines (past) | <input type="checkbox"/> Amphetamines (present) |
| <input type="checkbox"/> Barbiturates (past) | <input type="checkbox"/> Barbiturates (present) | <input type="checkbox"/> Cocaine (past) | <input type="checkbox"/> Cocaine (present) |
| <input type="checkbox"/> Crystal Meth | <input type="checkbox"/> Heroin (past) | <input type="checkbox"/> Heroin (present) | <input type="checkbox"/> Marijuana (past) |
| <input type="checkbox"/> Marijuana (present) | | | |

Male Children:

- | | | |
|----------------------------------------|-----------------------------------------|-----------------------------------------|
| <input type="checkbox"/> under 6 years | <input type="checkbox"/> under 10 years | <input type="checkbox"/> under 19 years |
|----------------------------------------|-----------------------------------------|-----------------------------------------|

Female Children:

- | | | |
|----------------------------------------|-----------------------------------------|-----------------------------------------|
| <input type="checkbox"/> under 6 years | <input type="checkbox"/> under 10 years | <input type="checkbox"/> under 19 years |
|----------------------------------------|-----------------------------------------|-----------------------------------------|

Occupational Activities:

- | | | | |
|------------------------------------------------|-----------------------------------------|---------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Retired | <input type="checkbox"/> administration | <input type="checkbox"/> business owner | <input type="checkbox"/> clerical/secretarial |
| <input type="checkbox"/> computer user | <input type="checkbox"/> construction | <input type="checkbox"/> daycare/childcare | <input type="checkbox"/> executive/legal |
| <input type="checkbox"/> food service industry | <input type="checkbox"/> healthcare | <input type="checkbox"/> heavy equipment operator | <input type="checkbox"/> heavy manual labor |
| <input type="checkbox"/> home services | <input type="checkbox"/> household | <input type="checkbox"/> light manual labor | <input type="checkbox"/> manufacturing |
| <input type="checkbox"/> medium manual labor | <input type="checkbox"/> military | <input type="checkbox"/> police/fire | <input type="checkbox"/> professional services |
| <input type="checkbox"/> retail worker | <input type="checkbox"/> teacher | <input type="checkbox"/> truck driver | |

Recreational Activities:

- | | | | |
|--------------------------------------|-----------------------------------------|--------------------------------------|--------------------------------------------|
| <input type="checkbox"/> backpacking | <input type="checkbox"/> biking | <input type="checkbox"/> boating | <input type="checkbox"/> exercise machines |
| <input type="checkbox"/> football | <input type="checkbox"/> golf | <input type="checkbox"/> racket ball | <input type="checkbox"/> running |
| <input type="checkbox"/> skiing | <input type="checkbox"/> soccer | <input type="checkbox"/> swimming | <input type="checkbox"/> tennis |
| <input type="checkbox"/> walking | <input type="checkbox"/> weight lifting | | |

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

Cardiovascular:

	No <input type="checkbox"/>	
	Present	Past
Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of Legs	<input type="checkbox"/>	<input type="checkbox"/>

Genitourinary:

	No <input type="checkbox"/>	
	Present	Past
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Lower Side Pain	<input type="checkbox"/>	<input type="checkbox"/>
Burning Urination	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stone	<input type="checkbox"/>	<input type="checkbox"/>

Hematologic/Lymphatic:

	No <input type="checkbox"/>	
	Present	Past
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Fever/Chills/Sweats	<input type="checkbox"/>	<input type="checkbox"/>

Endocrine:

	No <input type="checkbox"/>	
	Present	Past
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>
Menopausal	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory:

	No <input type="checkbox"/>	
	Present	Past
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Cold/Flu	<input type="checkbox"/>	<input type="checkbox"/>
Cough/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>

Ears/Nose/Throat:

	No <input type="checkbox"/>	
	Present	Past
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Infection	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleed	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>

Eyes:

	No <input type="checkbox"/>	
	Present	Past
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>

Integumentary:

	No <input type="checkbox"/>	
	Present	Past
Skin Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>

Allergic/Immunologic:

	No <input type="checkbox"/>	
	Present	Past
Hives	<input type="checkbox"/>	<input type="checkbox"/>
Immune Disorder	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Allergy Shots	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Use	<input type="checkbox"/>	<input type="checkbox"/>
Food Sensitivities	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Sensitivities	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric:

	No <input type="checkbox"/>	
	Present	Past
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Unusual Stress	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal:

	No <input type="checkbox"/>	
	Present	Past
Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal:

	No <input type="checkbox"/>	
	Present	Past
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
Joints Replaced	<input type="checkbox"/>	<input type="checkbox"/>

Neurological:

	No <input type="checkbox"/>	
	Present	Past
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Brain Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Severe Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Pinched Nerves	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel	<input type="checkbox"/>	<input type="checkbox"/>
Spinning/Balance	<input type="checkbox"/>	<input type="checkbox"/>

Constitutional:

	No <input type="checkbox"/>	
	Present	Past
Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>
Energy Level Problem	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>