Patient Health History

Today's Date _____ Patient Title: (check one) ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr.

First Name _____ Middle Name _____

Last Name _____ DOB ___/___/_____ Age _____

Address _____ SSN _____

City _____ State _____ Zip Code _____

Primary Phone _____ Work Phone _____

Mobile Phone _____ Email _____
(By Providing my email I authorize my Doctor to contact me by email)

Emergency Contact: _____ Relationship: _____ Phone _____

Contact Method (circle one) Primary Phone Work Phone Mobile Phone

Employment Status (circle one) Employed Self Employed Retired FT Student Other

Occupation _____ Employer _____

Work Address _____

Spouse's Name _____ DOB ___/___/___ SSN _____

Spouse's Employer _____ Work Phone _____

Referred By? _____ Number of Children & Ages _____

Have you received Chiropractic care before: Y N If Yes when/where _____

List chief complaints 1) _____ date symptoms started _____

2) _____ date symptoms started _____

What functions are you unable to perform (Example: walking, sitting, bending, laying, etc.) list all:

_____

Have you missed any work because of these complaints? Y N If yes, When? _____

Was this related to an accident? Y N If Yes Auto Work Other _____

Accident date ___/___/___ Describe accident _____

_____

List Doctors consulted for you current condition Primary Care Physician _____

1) _____ Diagnosis _____

2) _____ Diagnosis _____

Financial Arrangements

Method of Payment: Check Cash Debit/Credit Do you want us to file your Insurance Y N

Insurance Company _____ Secondary Insurance _____

Name of Policy Holder _____ Name of Policy Holder _____

DOB ___/___/___ Employer _____ DOB ___/___/___ Employer _____

Address if different from above _____ 1st or 2nd

Clinic policy requires payment arrangements be made on the first visit and/or Insurance verification.

Patient Signature: _____ Date ___/___/___

(If minor Parent/Guardian) _____

To be performed by clinic staff:

Height: _____ inches Weight: _____ pounds BP: _____/_____

PERSONAL HISTORY

X Presently have

___ Cancer
___ High Blood Pressure
___ Heart Trouble
___ Chest Pain
___ Shortness of Breath
___ Diabetes
___ Hypoglycemia
___ Hepatitis
___ Multiple Sclerosis
___ Epilepsy
___ Concussion
___ Dizziness/Fainting
___ Arthritis
___ Neuritis
___ Bursitis
___ Rheumatic Fever
___ Asthma
___ Digestive Disorder
___ Low back pain
___ stroke
___ Numbness
___ Anemia
___ Headache
___ Kidney Problems
___ Trouble Urinating
___ Bowel Troubles
___ Constipation/Diarrhea
___ Muscle Spasms
___ Leg Cramps
___ Swelling of Hands & Feet
___ Grinding sounds of neck
___ Depression
___ Chronic Fatigue
___ Weight loss
___ Weight gain
___ Scoliosis
___ Fever blisters/Cold sores
___ Sinus trouble
___ Neck pain
___ Pacemaker

√ Have had in the past

Women Only:
___ Birth Control Pills
___ Hysterectomy
___ Menstrual Pain
___ Breast Pain
Pregnant? Yes No

Men Only:
___ Prostate Trouble
___ Leakage after Urination

Do You:
___ Drink Coffee___ cups/day
___ Drink Tea___ cups/day
___ Drink Alcohol
Frequency? _____

Other Health Problems/Surgeries

_____
_____
_____
_____
_____
_____
_____

Family History:
___ Cancer
___ High Blood Pressure
___ Low back pain
___ Heart trouble
___ Diabetes
___ Scoliosis

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former Smoker ☐ Never been a smoker
If yes, how often do you smoke? ☐ Current every day smoker ☐ Current sometimes smoker

Current medications: ☐ Check here if no current medications ☐ Check here if we copied a list

	Generic/Brand name	Dosage		Generic/Brand name	Dosage
1)			5)		
2)			6)		
3)			7)		
4)			8)		

List any known Medication allergies: ☐ Check here if no known

_____

Race
___ American Indian or Alaska Native
___ Asian
___ Black/African American
___ Native Hawaiian or other pacific island
___ White
___ I choose not to specify

Ethnicity
___ Hispanic/Latino
___ Not Hispanic/Latino
___ I choose not to specify

Preferred Language
___ English
___ Spanish
___ Other_____
___ I choose not to specify

Patient Signature: _____ **Date:** ___/___/_____