

**NEW PATIENT INFORMATION**

FIRST NAME \_\_\_\_\_ MID \_\_\_\_\_ LAST \_\_\_\_\_

WHAT NAME WOULD YOU LIKE  
TO BE CALLED IN THIS OFFICE? \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT # \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_ EMAIL \_\_\_\_\_

TELEPHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

SS # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE NUMBER \_\_\_\_\_

OCCUPATION \_\_\_\_\_

PLEASE LIST THE FIRST AND LAST NAMES OF YOUR RELATIVES THAT ARE PATIENTS IN OUR OFFICE:

\_\_\_\_\_

WHO CAN WE CONTACT ON YOUR BEHALF IN CASE OF EMERGENCY?

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_

WORK PHONE NUMBER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

REFERRED TO THIS OFFICE BY: \_\_\_\_\_

DO YOU HAVE PERSONAL HEALTH INSURANCE THAT COVERS CHIROPRACTIC CARE? \_\_\_\_\_

PRIMARY SUBSCRIBER NAME \_\_\_\_\_

SUBSCRIBER # \_\_\_\_\_ SUBSCRIBER BIRTH DATE \_\_\_\_\_

HAS YOUR PRESENT NEED FOR TREATMENT ARISEN SPECIFICALLY FROM A WORK INJURY, AUTO ACCIDENT, OR  
OTHER INJURY FOR WHICH YOU ARE SEEKING REIMBURSEMENT FROM A PARTY OTHER THAN YOUR OWN  
INSURANCE? \_\_\_\_ YES \_\_\_\_ NO

WHAT WAS THE DATE OF ACCIDENT OR INJURY? \_\_\_\_\_

SIGNATURE OF PATIENT OR GUARDIAN \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

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I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS INSURANCE  
CLAIM FORMS RELATED TO SERVICES OR SUPPLIES RECEIVED FROM THIS OFFICE.

SIGNATURE \_\_\_\_\_  
REV. MAY 3, 2008

VENTURA CHIROPRACTIC & MASSAGE

## HEALTH HISTORY QUESTIONNAIRE

Please briefly answer the following.

<b>What are you here to be treated for?</b>	
When did it start?	How often does this bother you?
What brought it on?	
Note specifically where this occurs in your body?	
If you are experiencing pain, describe it.	
What makes it worse?	
What makes it better?	
Does this problem seem related to other symptoms you experience?	
Please list treatment you have had for this condition.	
Have you had this condition or a similar condition before?	

**PLEASE READ THIS CAREFULLY!** - The questions below do not necessarily relate to the care of your spine, but will give the doctor a clear picture of your overall health. Please note **ALL** your health problems even if you are not here for their treatment. Please make a check in the appropriate box, "**N**" to indicate problems you have now, "**P**" to indicate a problem in the past, or "**NP**" to indicate now and the past.

N	P	N/P		N	P	N/P	
			<b><u>SKIN, HAIR, NAILS</u></b>				<b><u>NOSE &amp; SINUSES</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unusual changes in skin, hair, or nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obstructions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stretch marks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain
			<b><u>HEAD</u></b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drainage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colds (frequent)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting				<b><u>MOUTH &amp; THROAT</u></b>
			<b><u>EYES</u></b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent infections
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Canker sores
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
			<b><u>EARS</u></b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gagging / Choking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive wax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing pills
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ringings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unusual taste in mouth
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Discharges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gum disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sense of fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Root canals
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Popping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain or problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss				<b><u>HEART</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pains
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure

N P N/P

**LUNGS**

- Coughing (unusual or excessive)
- Difficulty breathing
- Snoring
- Unusual breath odors

**DIGESTIVE SYSTEM**

- Pain
- Excessive gas
- Burning or Reflux
- Nausea
- Constipation
- Diarrhea or loose stools
- Hemorrhoids

Number of Bowel movements per day \_\_\_\_\_

Circle: hard normal loose

**GENITOURINARY SYSTEM**

- Get up to urinate at night
- Painful urination
- Difficult urination
- Blood in urine
- Loss of urine with activities

**NERVOUS SYSTEM**

- Numbness
- Tingling
- Muscle twitching
- Loss of balance
- Loss of coordination
- Nervousness
- Difficulty sleeping
- Ticklishness

**MUSCULOSKELETAL SYSTEM**

- Muscle pain
- Cramps
- Joint pain
- Neck pain or stiffness
- Arm pain associated w/ neck pain
- Low back pain
- Leg pain asso. w/ low back pain
- Mid back pain

**QUESTIONS FOR MALES**

- Prostate problems
- Testicular pain
- Impotence

**QUESTIONS FOR FEMALES**

- \_\_\_\_\_ Have you begun menopause?
- \_\_\_\_\_ Are you pregnant?
- \_\_\_\_\_ Age menstruation began?
- \_\_\_\_\_ Date your last period began?
- Irregular periods
- Discomfort with periods
- Spotting between periods
- Premenstrual syndrome
- Breast lumps
- Pain with intercourse
- Infertility
- Taking hormones

**MISCELLANEOUS**

Do you sleep on your stomach? \_\_\_\_\_

**SURGERIES & HOSPITALIZATIONS**

Please list conditions and approx year.

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**INJURIES** - Please list by year, broken bones, concussions, falls, auto accidents .....

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**X-RAYS** - Please list spinal x-rays and approximate dates within the last 10 years.

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**FAMILY** - Please list conditions that you believe run hereditarily in your family.

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**MEDICAL DOCTORS & MEDICATION**

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**PERSONAL** - Do you drink alcohol? How much?

Do you smoke? How much?

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Do you use recreational drugs? \_\_\_\_\_  
Any other health problems you have, even if you or your MD have decided that nothing can be done about them.

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