**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 _____

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 _____

SPOUSE'S NAME _____ EMPLOYER _____

WORK PHONE NUMBER _____ OCCUPATION _____

REFERRED TO THIS OFFICE BY: _____

DO YOU HAVE PERSONAL HEALTH INSURANCE THAT COVERS CHIROPRACTIC CARE? _____

IF YES, COMPLETE NAME OF INSURANCE COMPANY _____

PRIMARY SUBSCRIBER NAME & DATE OF BIRTH _____

SUBSCRIBER # _____ INS GROUP # _____

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 _____

**********

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 _____

## HEALTH HISTORY QUESTIONAIRE

Please briefly answer the following.

| **What are you here to be treated for?** | |
|---|---|
| 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 | |
|---|---|---|---|
| | | | **SKIN, HAIR, NAILS** |
| ☐ | ☐ | ☐ | Unusual changes in skin, hair, or nails |
| ☐ | ☐ | ☐ | Stretch marks |
| | | | **HEAD** |
| ☐ | ☐ | ☐ | Injury |
| ☐ | ☐ | ☐ | Headaches |
| ☐ | ☐ | ☐ | Dizziness |
| ☐ | ☐ | ☐ | Fainting |
| | | | **EYES** |
| ☐ | ☐ | ☐ | Pain |
| ☐ | ☐ | ☐ | Double vision |
| ☐ | ☐ | ☐ | Blurred vision |
| | | | **EARS** |
| ☐ | ☐ | ☐ | Pain |
| ☐ | ☐ | ☐ | Excessive wax |
| ☐ | ☐ | ☐ | Ringing |
| ☐ | ☐ | ☐ | Discharges |
| ☐ | ☐ | ☐ | Sense of fullness |
| ☐ | ☐ | ☐ | Popping |
| ☐ | ☐ | ☐ | Hearing loss |
| ☐ | ☐ | ☐ | Infections |
| ☐ | ☐ | ☐ | Itching |

| N | P | N/P | |
|---|---|---|---|
| | | | **NOSE & SINUSES** |
| ☐ | ☐ | ☐ | Obstructions |
| ☐ | ☐ | ☐ | Pain |
| ☐ | ☐ | ☐ | Drainage |
| ☐ | ☐ | ☐ | Bleeding |
| ☐ | ☐ | ☐ | Colds (frequent) |
| ☐ | ☐ | ☐ | Allergies |
| | | | **MOUTH & THROAT** |
| ☐ | ☐ | ☐ | Pain |
| ☐ | ☐ | ☐ | Frequent infections |
| ☐ | ☐ | ☐ | Canker sores |
| ☐ | ☐ | ☐ | Hoarseness |
| ☐ | ☐ | ☐ | Gagging / Choking |
| ☐ | ☐ | ☐ | Difficulty swallowing |
| ☐ | ☐ | ☐ | Difficulty swallowing pills |
| ☐ | ☐ | ☐ | Unusual taste in mouth |
| ☐ | ☐ | ☐ | Gum disease |
| ☐ | ☐ | ☐ | Root canals |
| ☐ | ☐ | ☐ | Jaw pain or problems |
| | | | **HEART** |
| ☐ | ☐ | ☐ | Chest pains |
| ☐ | ☐ | ☐ | 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.

_____

_____

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

_____

_____

_____

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

_____

_____

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

_____

_____

## MEDICAL DOCTORS & MEDICATION

_____

_____

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

_____

Do you smoke? How much?

_____

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.

_____

_____