Patient History Form

Date: _____

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Information

Name _____ DOB _____ Sex M F

Address _____ City _____ State ___ Zip _____

Cell Phone _____ Email _____

Employer/Occupation _____ Referred Here by _____

Emergency Contact _____

Phone _____ Relationship _____

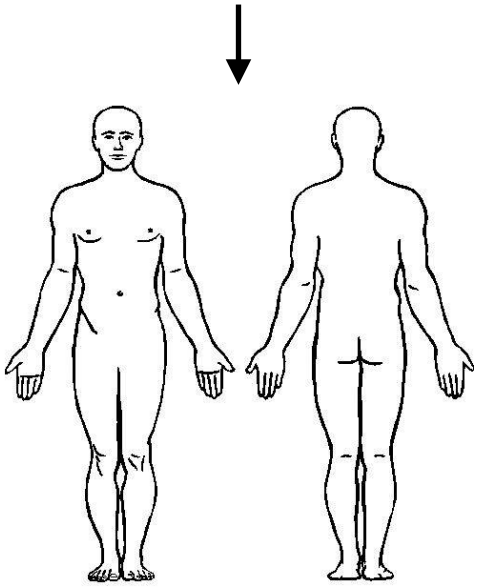
Insurance Type _____ **2ndary Insurance Type** _____

Patient Condition

Reason for visit _____

When did symptoms appear? _____ Is condition progressively worsening? *Yes No*

Mark an X on the picture where you continue to have pain, numbness or tingling.



Rate the severity of your pain from 1 (least) to 10 (severe) _____

Is your pain: *constant comes & goes*

How often do you have this pain? _____

Type of pain: *sharp dull throbbing numbness aching shooting burning tinging cramps stiffness swelling other* _____

Does your pain interfere with: *work sleep daily routine recreation N/A*

Activities or movements that are painful to perform:

sitting standing walking bending lying down N/A

Accident Information N/A

Type of Accident: *auto work home other*_____ Date: _____

Have you reported you accident to: *Auto Ins Employer Worker's Comp Other*_____

Health History

What treatment have you already received for your condition?

medication PT chiropractic surgery none other: _____

Name of other practitioner(s) whom have treated your condition: _____

Date of Last: Physical _____ Spinal X-Ray _____ Blood Test _____

Chest X-Ray _____ Spinal Exam _____ Urine Test _____

Dental X-Ray _____ MRI, CT Scan, Bone Scan _____

Indicate if you have had any of the following:

AIDS/HIV	*Chicken Pox*	*Liver Disease*	*Rheumatoid Arthritis*
Alcoholism	*Diabetes*	*Measles*	*Rheumatic Fever*
Allergy Shots	*Emphysema*	*Migraines*	*Scarlet Fever*
Anemia	*Epilepsy*	*Miscarriage*	*Stroke*
Anorexia	*Fractures*	*Mononucleosis*	*Suicide Attempt*
Appendicitis	*Glaucoma*	*Multiple Sclerosis*	*Thyroid Problems*
Arthritis	*Goiter*	*Mumps*	*Tonsillitis*
Asthma	*Gonorrhea*	*Osteoporosis*	*Tuberculosis*
Bleeding Disorders	*Gout*	*Pacemaker*	*Tumors, Growths*
Breast Lump	*Heart Disease*	*Parkinson's*	*Typhoid Fever*
Bronchitis	*Hepatitis*	*Pinched Nerve*	*Ulcers*
Bulimia	*Hernia*	*Pneumonia*	*Vaginal Infections*
Cancer	*Herniated Disk*	*Polio*	*Venereal Disease*
Cataracts	*Herpes*	*Prostate Problems*	*Whooping Cough*
Chemical Dependency	*High Cholesterol*	*Prosthesis*	*Other:* _____
	Kidney Disease	*Psychiatric Care*	_____

Allergies _____ **Current Pregnancy?** ***No Yes*** **Due Date:** _____

Exercise: *None Moderate Daily Heavy* **Work Activity:** *Sitting Standing Light Labor Heavy Labor*

Habits: *Smoking - Packs/Day* _____ *Alcohol - Drinks/Week* _____ *Caffeine Drinks - Cups/Day* _____

High Stress Level - Reason _____

SDOH: Are you struggling with basic needs such as food, housing, safety, etc? *Yes No*

Injuries/Surgeries	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications _____

Vitamins/Herbs/Minerals _____