

New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name Last Name Date Email*
* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address City State Zip
Telephone (Work) (home) Referred By
Age Birth Date Social Security # Number of Children
Occupation Employer
Marital Status Spouse's Name Spouse's Occupation
Spouse's Employer Spouse's Health Status
Emergency Contact Phone

Current Complaints

Nature of Injury:
Please describe:
Date of Injury Date symptoms appeared
Have you ever had same condition? No Yes If yes, when?
List of other practitioners seen for this injury/condition
Have you ever been under chiropractic care? No Yes
If yes, please describe

Insurance Information

Name of party responsible for payment Phone
Do you have health insurance? No Yes Name of company
*** If an auto accident, please provide:**
Insurance Company Name Contact Person
Phone: Claim #

Signatures

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure for your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent: *You may request restrictions on your disclosure. *You may request to view changes to your records. *You may inspect and receive copies of your records within 30 days with a request. *In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and it's staff. I understand, the under Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: *Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly. *Obtain payment from third party payers. *Conduct normal healthcare operations such as quality assessments and physician's certifications. **I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal health information is used or disclosed.**

Patient Initials _____

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I understand that the Doctor's office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt. I understand that I am financially responsible for all the charges on my account, in the event of a default on payment; responsible party will pay collection costs and reasonable attorney fees totaling 40% of the amount and any future outstanding amounts.

Patient Initials _____

Ownership of X-rays

It is understood and agreed that the payments to the Doctor regarding x-rays are for diagnostic reading of the x-rays, not the x-ray itself. The x-ray negative and digital file will remain property of the office. These files are kept and may be seen at anytime during the course of treatment. Copies can be made; the copy fee is \$10.00.

Patient Initials _____

Terms of Acceptance

When a patient seeks Chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to obtain it. This will prevent any confusion and disappointment. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease. Vertebral subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health. **I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.**

Patient Initials _____

Patient's Name: _____

Patient's Signature: _____ Date: _____

Relationship to Patient: _____

Medical History

Have you been treated for any conditions in the last year? No Yes
 If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc.)

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had surgery?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	<input type="radio"/> No	<input type="radio"/> Yes
Do your symptoms interfere with daily life?	<input type="radio"/> No	<input type="radio"/> Yes
Does pain wake you up at night?	<input type="radio"/> No	<input type="radio"/> Yes
Are your symptoms worse during certain times of the day?	<input type="radio"/> No	<input type="radio"/> Yes
Do changes in weather affect your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
Do you wear orthotics?	<input type="radio"/> No	<input type="radio"/> Yes
Do you take vitamin supplements?	<input type="radio"/> No	<input type="radio"/> Yes
What activities aggravate your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
<input type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes

Habits	None	Light	Moderate	Heavy
--------	------	-------	----------	-------

Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever suffered from:	
-------------------------------------	--

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems or Insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing

