New Patient Health History Form

Today's Date____/____/____

First Name:____________________ Middle:__________ Last:______________________________

Address:__________________________________City:________________ State:_____ Zip__________

Email Address:____

Phone: **Cell** ____________________Home _____________________ Work_____________________

Birth Date:____/____/____ Age:___________ Social Security#: _______/______/______

Circle One: Single Married Divorced Widowed Other_______ Number of Children___________

Occupation:_______________________________ Employer:___________________________________

Emergency Contact: ____________________Phone: _______________ Relationship: ______________

How did you hear about us?

Referred by: ________________Advertisement:____________Internet:____________Other:______________

Insurance Information:

Do you have health insurance? ____Yes ____No

Primary Insurance Company_______________________________Policy#__________________

Primary Policy Holder Name_______________________________DOB____________________

Secondary Insurance Company_____________________________Policy#__________________

Secondary Policy Holder Name_____________________________DOB____________________

Signatures:

Name of the insured____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature____Date____/____/____

Spouse's or Guardian's Signature_________________________________Date____/____/____

Current Health Concerns: Please list your top three health concerns at the moment

1.______________________________ **Is this health concern related to: □Work □Auto Accident □Other**

Date Began:_________/_________/_________

What makes it better?_____________________________ What makes it worse?_________________

Have you seen other practitioners for this injury/condition?_________________________________

If yes, what medications or treatments were given?_______________________________________

2.______________________________ **Is this health concern related to: □Work □Auto Accident □Other**

Date Began:_________/_________/_________

What makes it better?_____________________________ What makes it worse?_________________

Have you seen other practitioners for this injury/condition?_________________________________

If yes, what medications or treatments were given?_______________________________________

3.______________________________ **Is this health concern related to: □Work □Auto Accident □Other**

Date Began:_________/_________/_________

What makes it better?_____________________________What makes it worse?__________________

Have you seen other practitioners for this injury/condition?_________________________________

If yes, what medications or treatments were given?_______________________________________

Medical History:

Date of last physical exam:____/____/____

Is there a chance that you are pregnant? Yes____ No____

Have you ever had X-Rays taken? Yes____ No____ If yes, where?____________________

Are you allergic to anything?____________________

Have you ever:

Broken bones? Yes_____No_____ Explain:____________________

Been hospitalized? Yes_____No_____ Explain:____________________

Been in an auto accident? Yes_____No_____ Explain:____________________

Had Sprains/Strains? Yes_____No_____ Explain:____________________

Struck unconscious? Yes_____No_____ Explain:____________________

Had surgery? Yes_____No_____ Explain:____________________

Family History: Please list past and present health conditions (ie: heart disease, cancer, diabetes, etc.)

Family Member	Health Condition

Habits:	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

What medications are you currently taking and for what conditions? Please list dosage, amounts, etc.:____________________

What vitamins, minerals, herbs or other supplements do you currently take? Please list dosage, amounts, etc.:

Do you have any opinions regarding what may have caused your health conditions?____________________

What would you like most to improve with regards to your health?____________________

Attaining better health and wellness would allow you to?____________________

Are you willing to take an active part in achieving health and wellness?____________________

Is your health better today than it was five years ago?____________________

Do you believe your health can be improved over the next year?____________________

How much have you spent ($) on supplements/RX/Co-Pays monthly?____________________

What can we do to make your experience here exceptional?____________________

This center has been built on referrals. What could we do that would make you refer your friends and family?

Please indicate if you have ever experienced any of the following:

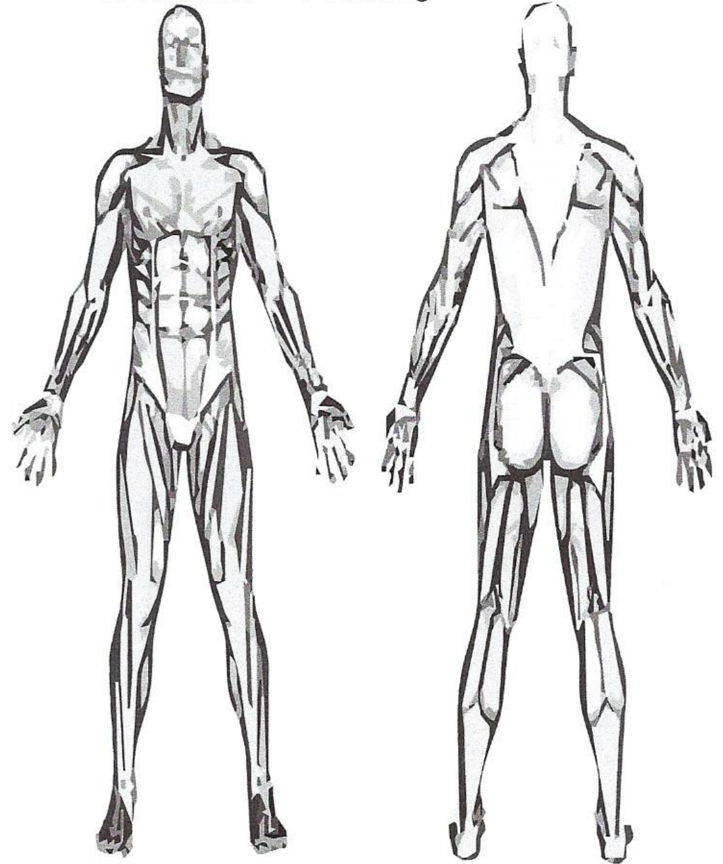
Mark X for current issue and P for past issue

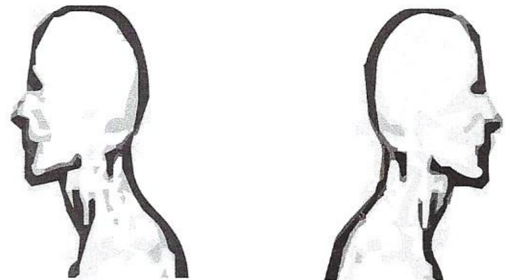
- ☐ Alcoholism__________
- ☐ Allergies__________
- ☐ Anemia__________
- ☐ Anxiety/Nervousness__________
- ☐ Arteriosclerosis__________
- ☐ Arthritis__________
- ☐ Asthma__________
- ☐ Back Pain__________
- ☐ Breast Lump__________
- ☐ Bronchitis__________
- ☐ Bruise Easily__________
- ☐ Cancer__________
- ☐ Chest Pain__________
- ☐ Cold Extremities__________
- ☐ Constipation__________
- ☐ Cramps__________
- ☐ Depression__________
- ☐ Diabetes__________
- ☐ Digestion Issues__________
- ☐ Dizziness__________
- ☐ Ears Ring__________
- ☐ Excessive/Scanty Menstruation__________
- ☐ Eye Pain or Difficulties__________
- ☐ Fatigue__________
- ☐ Frequent/Scanty Urination__________
- ☐ Headache/Migraines__________
- ☐ Heartburn/Reflux/GERD__________
- ☐ Hemorrhoids__________
- ☐ High Blood Pressure__________
- ☐ Hot Flashes__________
- ☐ Irregular Heartbeat__________
- ☐ Irregular Cycle__________
- ☐ Kidney Infection__________
- ☐ Kidney Stones__________
- ☐ Loose Stools__________
- ☐ Loss of Memory__________
- ☐ Loss of Balance__________
- ☐ Loss of Smell__________
- ☐ Loss of Taste__________
- ☐ Low Libido__________
- ☐ Neck Pain or Stiffness__________
- ☐ Nosebleeds__________
- ☐ Pacemaker__________
- ☐ Polio__________
- ☐ Poor Posture__________
- ☐ Prostate Issues__________
- ☐ Sciatica__________
- ☐ Shortness of Breath__________
- ☐ Sinus Infection__________
- ☐ Sleep problems or Insomnia__________
- ☐ Spinal Curvatures__________
- ☐ Stroke__________
- ☐ Swelling of Ankles__________
- ☐ Swollen Joints__________
- ☐ Thyroid Condition__________
- ☐ Tuberculosis__________
- ☐ Ulcers__________
- ☐ Varicose Veins__________
- ☐ Venereal Disease__________

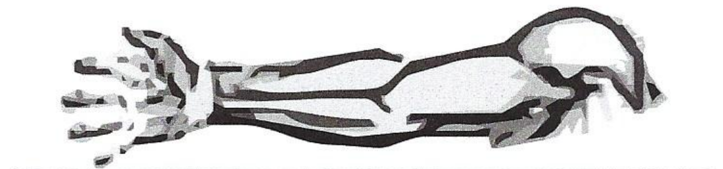
Other__________

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

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







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