

New Patient Health History Form

First Name: _____ Last Name: _____ Date of Service: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone # _____

Birthdate: _____ Age: _____ Sex: Male Female

Status: Minor Single Married Widowed Separated Divorced

Employer: _____ Occupation: _____

How did you hear about us? _____

In case of emergency notify: _____ Phone # _____ Relation: _____

HEALTH INSURANCE INFORMATION

Primary Insurance:

Insured's Name: _____ Relation: _____ Insured Date of Birth: _____

Insured's ID # _____ Group # (plan, local or policy) _____

Employer's Name Insurance is through: _____

* **Secondary Health Insurance: (If applicable)** _____

Insured's Name: _____ Relation: _____ Insured Date of Birth: _____

Insured's ID # _____ Group # (plan, local or policy) _____

Employer's Name Insurance is through: _____

If auto accident, please provide any attorney/adjuster information:

Attorney's name: _____ Phone #: _____

LIABLE Party Auto Insurance company name: _____ Claim #: _____

Liabile Adjuster's name: _____ Phone #: _____

YOUR Auto Insurance name (IF MEDPAY) : _____ Claim #: _____

Your Adjuster's name: _____ Phone #: _____

First Name: _____ Last Name: _____

Reason for today's visit: _____

Have you been seen by a chiropractor? Yes No Where/ Last date seen: _____

Have you been seen by any other physicians for this condition? Doctor's name: _____

Are you in pain? Yes No Rate your pain on a scale 1 – 10 _____

Did injury occur at: Work Sport/Play Auto Accident Routine Activity Other

Describe the injury _____

How did it occur? _____

When did it occur? _____

Where did it occur? _____

Is your condition getting worse? Yes No Constant Come and goes

MEDICAL HISTORY

List medications you are taking and what they are used for: _____

Please list any other medical condition (s) not listed above: _____

Any recent studies performed? (MRI, CT, XR) If yes, list which studies and where: _____

List any past surgeries OR accidents, include dates: _____

Please list anything you may be allergic to: _____

Family health history (Ex: Heart dz, Cancer, Diabetes, Etc): _____

Do you take any vitamins or supplements? Yes No Do you exercise? Yes No

Are you concerned with your weight or overall health? Yes No

Do you smoke? Yes No How much? _____ How long? _____

For Women:

Are you taking birth control? Yes No

Are you breast feeding? Yes No

Are you pregnant? Yes No If so, how long? _____

Do you have or have ever had in the past:

Heat Attack
Pacemaker
Heart Murmur / Defect
Artificial Valves
HIV+/ AIDS/ARC
Hepatitis
Difficulty Breathing
Shingles
High/low blood pressure
Ulcers/ Colitis
Psychiatric Problems
Alcohol/Drug Abuse
Cancer/Chemotherapy

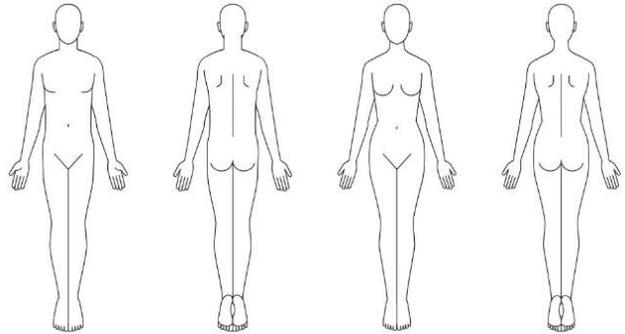
Stroke history
Fainting/Seizure
Facial drooping
Sinus Problems
Frequent Neck
Pain/Stiffness
Severe/Headaches

Glaucoma
Tuberculosis
Emphysema/Ashma
Anemia
Diabetes
Kidney Problems
Arthritis

Artificial Bones/ Joints
Dental Implants
Struck unconscious
Vision issues
Nauseous
Dizziness
Atherosclerosis
Swollen Joints
Loss of balance
Frequent Urination
Numb Extremities

Using the adjacent body charts, please circle all affected areas and label with corresponding letters:

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



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 personal 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: _____

Guardian's signature: _____ Date: _____