

# New Patient Health History

Name:		Today's Date:	
Date of Birth:	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:			
City:	State:	Zip:	
Home Phone:	Cell Phone:	Email:	
Best way to contact you: <input type="checkbox"/> Call Home <input type="checkbox"/> Call Cell <input type="checkbox"/> Text   Cell Carrier: _____ <input type="checkbox"/> Email			
Parent Name (If Minor):		Phone Number:	

**Referral Information**

How did you hear about our office? \_\_\_\_\_

**Emergency Information**

Emergency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_      Relationship: \_\_\_\_\_

**Current Health Condition**

Chief Complaint: (Why are you here today?)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Body Area Involved	<input type="checkbox"/> Neck <input type="checkbox"/> Mid-Back <input type="checkbox"/> Low-Back <input type="checkbox"/> Upper Extremity <input type="checkbox"/> Lower Extremity <input type="checkbox"/> Other: _____
Condition	<input type="checkbox"/> New (<6 weeks) <input type="checkbox"/> Exacerbation <input type="checkbox"/> Recurring <input type="checkbox"/> Chronic (>6 Weeks)
Onset Mechanism	<input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Over Exertion <input type="checkbox"/> Slip/Fall <input type="checkbox"/> Lifting <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Slept Wrong <input type="checkbox"/> No Injury <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____
Symptoms	<input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Numbness <input type="checkbox"/> Weakness
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral (Both Sides)
Quality	<input type="checkbox"/> Burning <input type="checkbox"/> Dull/Aching <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Tightness <input type="checkbox"/> Tingling <input type="checkbox"/> Diffuse <input type="checkbox"/> Localized <input type="checkbox"/> Radiating <input type="checkbox"/> Other: _____
Resting Pain Scale	0   1   2   3   4   5   6   7   8   9   10
Activity Pain Scale	0   1   2   3   4   5   6   7   8   9   10

When did symptoms start?	_____		
When did they get worse?	_____		
When did you have them last?	_____		
Has this happened before?	_____	If yes, When?	_____
Did a specific injury occur?	_____	If yes, When?	_____
Did a specific accident occur?	_____	If yes, When?	_____

When are the symptoms worst?	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> With Activity <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent
Associated Signs & Symptoms	<input type="checkbox"/> Blurred Vision <input type="checkbox"/> Nausea <input type="checkbox"/> Sleep Disturbance <input type="checkbox"/> Depression <input type="checkbox"/> Ringing In Ears <input type="checkbox"/> Irritability/Mood Swing <input type="checkbox"/> Stiffness <input type="checkbox"/> Dizziness <input type="checkbox"/> Localized Tingling <input type="checkbox"/> Headaches ( <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Throbbing <input type="checkbox"/> Stabbing <input type="checkbox"/> Aura) <input type="checkbox"/> Radiating ( <input type="checkbox"/> Left <input type="checkbox"/> Right) <input type="checkbox"/> Weakness ( <input type="checkbox"/> Left <input type="checkbox"/> Right)
	Other Signs & Symptoms

Symptoms <b>Better</b> With	<input type="checkbox"/> Activity <input type="checkbox"/> Bending <input type="checkbox"/> Cold <input type="checkbox"/> Heat <input type="checkbox"/> Massage <input type="checkbox"/> OTC Meds <input type="checkbox"/> RX Meds <input type="checkbox"/> Rest <input type="checkbox"/> Stretching <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Nothing Helps
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**Review of Systems**

Constitutional <input type="checkbox"/> Deny All	<input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss
Eyes <input type="checkbox"/> Deny All	<input type="checkbox"/> Blindness <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Cataracts <input type="checkbox"/> Change in Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Eye Pain <input type="checkbox"/> Field Tearing <input type="checkbox"/> Glaucoma <input type="checkbox"/> Itching <input type="checkbox"/> Photophobia <input type="checkbox"/> Tearing <input type="checkbox"/> Wears Glasses/Contacts
ENT <input type="checkbox"/> Deny All	<input type="checkbox"/> Bleeding <input type="checkbox"/> Dentures <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Discharge <input type="checkbox"/> Dizziness <input type="checkbox"/> Ear Drainage <input type="checkbox"/> Ear Pain <input type="checkbox"/> Fainting <input type="checkbox"/> Frequent Sore Throats <input type="checkbox"/> Headaches <input type="checkbox"/> Hearing Loss <input type="checkbox"/> History of Head Injury <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of Smell <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Postnasal Drip <input type="checkbox"/> Rhinorrhea <input type="checkbox"/> Sinus Infections <input type="checkbox"/> Snoring <input type="checkbox"/> Sore Throat <input type="checkbox"/> Tinnitus <input type="checkbox"/> TMJ
Respiratory <input type="checkbox"/> Deny All	<input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Coughing up Blood <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Sputum Production <input type="checkbox"/> Wheezing
Cardio <input type="checkbox"/> Deny All	<input type="checkbox"/> Angina <input type="checkbox"/> Chest Pain <input type="checkbox"/> Claudication <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Problems <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Orthopnea <input type="checkbox"/> Palpitations <input type="checkbox"/> PND <input type="checkbox"/> Shortness Of Breath with Exertion <input type="checkbox"/> Swelling of Legs <input type="checkbox"/> Ulcers <input type="checkbox"/> Varicose Veins
GI <input type="checkbox"/> Deny All	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Belching <input type="checkbox"/> Black Tarry Stools <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Jaundice <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting Blood
Female <input type="checkbox"/> Deny All	<input type="checkbox"/> Birth Control <input type="checkbox"/> Breast Lumps/Pain <input type="checkbox"/> Burning Urination <input type="checkbox"/> Cramps <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Hormone Therapy <input type="checkbox"/> Irregular Menses <input type="checkbox"/> Pregnancy <input type="checkbox"/> Urine Retention <input type="checkbox"/> Vaginal Bleeding <input type="checkbox"/> Vaginal Discharge
Male <input type="checkbox"/> Deny All	<input type="checkbox"/> Burning Urination <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Hesitancy/Dribbling <input type="checkbox"/> Prostate Problem <input type="checkbox"/> Urine Retention
Endocrine <input type="checkbox"/> Deny All	<input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Diabetes <input type="checkbox"/> Excessive Appetite <input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Frequency of Urination <input type="checkbox"/> Goiter <input type="checkbox"/> Hair Loss <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Unusual Hair Growth <input type="checkbox"/> Voice Changes
Skin <input type="checkbox"/> Deny All	<input type="checkbox"/> Changes in Nail Texture <input type="checkbox"/> Changes in Skin Color <input type="checkbox"/> Hair Growth <input type="checkbox"/> Hair Loss <input type="checkbox"/> Hives <input type="checkbox"/> History of Skin Disorders <input type="checkbox"/> Itching <input type="checkbox"/> Paresthesia <input type="checkbox"/> Rash <input type="checkbox"/> Skin Lesions/Ulcers <input type="checkbox"/> Varicosities
Neurologic <input type="checkbox"/> Deny All	<input type="checkbox"/> Dizziness <input type="checkbox"/> Facial Weakness <input type="checkbox"/> Headache <input type="checkbox"/> Limb Weakness <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Numbness <input type="checkbox"/> Seizures <input type="checkbox"/> Seizures <input type="checkbox"/> Sleep Disturbance <input type="checkbox"/> Slurred Speech <input type="checkbox"/> Stress <input type="checkbox"/> Strokes <input type="checkbox"/> Tremor <input type="checkbox"/> Loss of Balance
Psychologic <input type="checkbox"/> Deny All	<input type="checkbox"/> Anhedonia <input type="checkbox"/> Anxiety <input type="checkbox"/> Appetite <input type="checkbox"/> Behavioral Change <input type="checkbox"/> Bi-Polar <input type="checkbox"/> Confusion <input type="checkbox"/> Convulsions <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Memory Loss <input type="checkbox"/> Mood Change
Allergy <input type="checkbox"/> Deny All	<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Food Intolerance <input type="checkbox"/> Itching <input type="checkbox"/> Acute Nasal Congestion <input type="checkbox"/> Chronic Nasal Congestion <input type="checkbox"/> Rash <input type="checkbox"/> Sneezing
Hematologic <input type="checkbox"/> Deny All	<input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding <input type="checkbox"/> Blood Clotting <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Bruising <input type="checkbox"/> Fatigue <input type="checkbox"/> Lymph Node Swelling

**Employment**

Occupation:	Hours Worked Per Day:
Job Classification	<input type="checkbox"/> Sedentary <input type="checkbox"/> Light Lifting <input type="checkbox"/> Moderate Lifting <input type="checkbox"/> Heavy Lifting
Lifting	<input type="checkbox"/> Constant (66-100%) <input type="checkbox"/> Frequent (33-65%) <input type="checkbox"/> Occasional (0-32%)
Work Activities	<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Climbing <input type="checkbox"/> Pushing <input type="checkbox"/> Pulling <input type="checkbox"/> Kneeling <input type="checkbox"/> Reaching <input type="checkbox"/> Twisting <input type="checkbox"/> Bending
Repetitive Activities	<input type="checkbox"/> Computer <input type="checkbox"/> Phone <input type="checkbox"/> Machinery <input type="checkbox"/> Assembly <input type="checkbox"/> Hand Tools <input type="checkbox"/> Grasping
Effect on Job Performance	<input type="checkbox"/> Mild Painful (Can Do) <input type="checkbox"/> Moderate Painful (Can Do Limited) <input type="checkbox"/> Severe (Unable to perform) <input type="checkbox"/> Other: _____

**Daily Activities: To what level are you experiencing symptoms while performing these activities?**  
 0 – No Effect → 10 – Unable to do

Activity	0	1	2	3	4	5	6	7	8	9	10	Activity	0	1	2	3	4	5	6	7	8	9	10	
Bending												Bathing												
Carrying Groceries												Kneeling												
Change Sit to Stand												Sleep												
Child Care												Static Sitting												
Climb Stairs												Static Standing												
Computer Use												Yard Work												
Pet Care												Exercise												
Driving												Running												
Household Chores												Golf												
Lifting												Walking												
Reading												Swimming												
Dressing												Weight Lifting												

**Past Health History – Please fill out carefully as these problems can affect your overall course of care**

<b>Childhood Illness:</b> <input type="checkbox"/> Deny Childhood Illness	<input type="checkbox"/> ADD <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Fetal Drugs <input type="checkbox"/> Measles <input type="checkbox"/> Spina Bifida	<input type="checkbox"/> Allergies/Hay fever <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Food Allergies <input type="checkbox"/> Mumps <input type="checkbox"/> Other: _____	<input type="checkbox"/> Asthma <input type="checkbox"/> Depression <input type="checkbox"/> Headaches <input type="checkbox"/> Rash	<input type="checkbox"/> Eczema <input type="checkbox"/> Diabetes <input type="checkbox"/> Hepatitis <input type="checkbox"/> Scoliosis	<input type="checkbox"/> Bed Wetting <input type="checkbox"/> Ear Infections <input type="checkbox"/> HIV <input type="checkbox"/> Sickle Cell
<b>Adult Illness:</b> <input type="checkbox"/> Deny Adult Illness	<input type="checkbox"/> Alzheimer's <input type="checkbox"/> Crohn's/Colitis <input type="checkbox"/> Diabetes 1 <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Pneumonia <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Vertigo	<input type="checkbox"/> Anemia <input type="checkbox"/> CRPS (RSD) <input type="checkbox"/> Diabetes 2 <input type="checkbox"/> Heart Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Parkinson's <input type="checkbox"/> Shingles <input type="checkbox"/> Past history of similar symptoms	<input type="checkbox"/> Arthritis <input type="checkbox"/> CVA (Stroke) <input type="checkbox"/> Ear Infections <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> Pleurisy <input type="checkbox"/> STD's (Unspecified)	<input type="checkbox"/> Asthma <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Emphysema <input type="checkbox"/> Lupus (Discoid) <input type="checkbox"/> Psychiatric Problems <input type="checkbox"/> Suicide Attempt(s)	<input type="checkbox"/> Cancer <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Depression <input type="checkbox"/> Eye Problems <input type="checkbox"/> Hypertension <input type="checkbox"/> Influenza <input type="checkbox"/> Lupus (Systemic) <input type="checkbox"/> Scoliosis <input type="checkbox"/> Thyroid <input type="checkbox"/> Other: _____
<b>Surgeries:</b> <input type="checkbox"/> Deny Surgeries	<input type="checkbox"/> Angioplasty <input type="checkbox"/> Carpal Tunnel Repair <input type="checkbox"/> Dental Surgery <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Mastectomy <input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Appendectomy <input type="checkbox"/> Coronary Artery Bypass <input type="checkbox"/> Gall Bladder <input type="checkbox"/> Joint Reconstruction <input type="checkbox"/> Pacemaker Insertion <input type="checkbox"/> Other: _____	<input type="checkbox"/> Caesarean Section <input type="checkbox"/> Cosmetic <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Rotator Cuff	<input type="checkbox"/> Cardiac Catheterization <input type="checkbox"/> D & C <input type="checkbox"/> Hernia Repair <input type="checkbox"/> Laminectomy <input type="checkbox"/> Spinal Fusion	
<b>OB/GYN:</b> <input type="checkbox"/> Deny OB/GYN Issues	<input type="checkbox"/> I have never been pregnant <input type="checkbox"/> Complicated pregnancy <input type="checkbox"/> Vaginal delivery	<input type="checkbox"/> I have been pregnant in the past (# of pregnancies: _____) <input type="checkbox"/> Uncomplicated pregnancy <input type="checkbox"/> I am currently pregnant	<input type="checkbox"/> C-section delivery		

**Injuries:**     Back Injury     Broken Bones     Fracture     Severe Fall     Head Injury  
 Disability     Industrial Accident     Joint Injury     Severe Laceration  
 Motor Vehicle Accident     Mild/Moderate Soft Tissue Injury     Severe Soft Tissue Injury

**Previous Treatment**

Have you seen other doctors for this condition?     No     Yes – Name: \_\_\_\_\_  
Office Location: \_\_\_\_\_  
Describe Treatment: \_\_\_\_\_

**Please list or attach a copy of all Vitamins, Supplements, Rx and OTC Drugs you currently take and dosages**

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What would you love to be doing that you are unable to do now?	
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What would you love to be doing better that you can already do now?	
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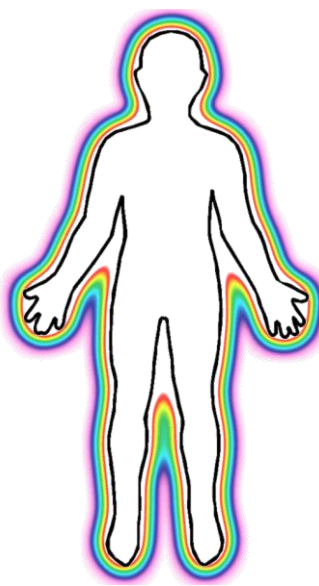
**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

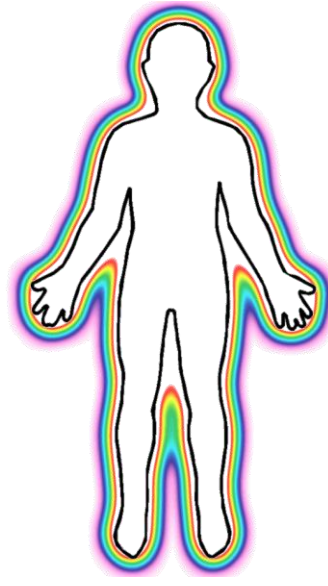
Signature	Date:
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**Please Circle Areas of Complaint. Use the following letters to describe your symptoms:**

- S – Stiffness
- B – Burning
- N – Numbness
- P – Sharp Pain
- T – Tingling
- D – Dull Pain



Front



Back