# NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

**WELCOME:** The doctor and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

**INSTRUCTIONS:** Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

## PERSONAL INFORMATION:

**Today's Date: _____ /_____/_____**

Name: (*First*)_____ (*Middle*)_____(*Last*)_____

Preferred Name: _____ Gender (*Circle*): Male / Female

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

Birth Date: _____ /_____/_____ Age:_____ Marital Status (*Circle*): Divorced Married Single Separated Widowed

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Social Security #: _____-_____-_____ Email Address: _____

Spouses Name: _____

Names & Ages of Children: _____

How were you referred to our office? _____

**Employer /Employment Status**

Occupation/Job Title:: _____ Employer: _____

Business Phone: (_____) _____-_____ Type of Work:_____

Spouse's Occupation _____Employer: _____

**Emergency Contact Information**

Name: _____

Relationship: _____ Phone: (_____) _____-_____

Your Primary Doctor's Name:_____. If necessary, may we update your doctor? Yes or No

**Race**: □ White □ Black/African American □ Hispanic/Latino □ Asian □ Native American Other:_____

□ I choose not to specify

**Ethnicity** □ Hispanic or Latino □ Not Hispanic or Latino □ I choose not to specify

**Preferred Language**: □ English □ Spanish □ French □ Japanese □ Chinese □ German □ Other_____

□ I choose not to specify

**PRIMARY COMPLAINT:**

_____

When did it start? _____

Describe the condition:_____

What do you think caused the problem?_____

Rate the pain from 1-10: At it's worst _____ At the present time _____

Does the pain travel? **Yes / No** If yes, from where to where? _____

Is condition getting worse? **Yes / No** What makes it worse? _____

How often do you experience your symptoms? □ 25% of the day □ 50% of the day □ 75% of the day □ 100% of the day

List the activities that this condition prevents you from doing? _____

_____

List past treatment for this condition and if they helped _____

_____

**SECOND COMPLAINT (IF APPLICABLE):**

_____

When did it start? _____

Describe the condition:_____

What do you think caused the problem?_____

Rate the pain from 1-10: At it's worst _____ At the present time _____

Does the pain travel? **Yes / No** If yes, from where to where? _____

Is condition getting worse? **Yes / No** What makes it worse? _____

How % of the day do you experience symptoms? □ 25% □ 50% □ 75% □ 100%

List the activities that this condition prevents you from doing? _____

_____

List past treatment for this condition and if they helped _____

**LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:**

_____

_____

_____

**Are you pregnant or may be pregnant? Yes / No**

**LIST OF PREVIOUS SURGERIES:**

_____

_____

## HEALTH HISTORY

| **Check all below that apply to you currently or in the past** | | | | **Family History** Mark all that run in your family | | Relationship |
|---|---|---|---|---|---|---|
| | Osteoarthritis | | Whiplash Injury | | Cancer | |
| | Asthma | | Headaches/Migraines | | Anemia | |
| | Diabetes | | Scoliosis | | Diabetes | |
| | Anemia | | Osteoporosis | | Heart Problems | |
| | Cancer/Tumor | | Epilepsy | | High Blood Pressure | |
| | Rheumatoid Arthritis | | Fibromyalgia | | Genetic Disorders | |
| | Depression/Anxiety | | Genetic Disorders | | Scoliosis | |
| | Disc Herniation | | Multiple Sclerosis | | Multiple Sclerosis | |
| | High Blood Pressure | | Heart Disease/Stroke | | | |
| | Thyroid Condition | | Other : | | Other | |

## SOCIAL HISTORY

Alcohol: **Daily Weekly Occasionally Never** Drugs: **Daily Weekly Occasionally Never**

Do you currently smoke tobacco of any kind? **Yes / No** How often? **Daily Weekly Occasionally**

How many times per week do you exercise? _____

What are your hobbies? _____

What % of time during the day do you spend: Lifting _____ Sitting _____ Working at computer _____

Is there any other information that you feel would be relevant to your current condition(s) that was not covered?

Please explain in the following section any information that you feel would be helpful to the doctor.

_____

_____

**As a courtesy our office utilizes text message reminders for your appointments, These reminders only occur once the day before any appointment. Do we have your permission to send you these reminders? Yes or No**

**PAYMENT/INSURANCE INFORMATION:**

Is the condition(s) that brought you here today due to an auto accident or on the job injury? **Yes / No**

Will you be filing health insurance with our office? **Yes / No**

Personal Health Insurance Carrier: _____

Supplemental Policy Carrier (if applicable) _____

Insurance Member ID #:_____

**INFORMED CONSENT TO TREATMENT:**

I certify that I'm the patient or legal guardian listed above. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand that fees for services will become immediately due upon suspension or termination of my care or treatment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, dislocations, muscle strain, and costovertebral strains. Fractures are very rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination. Some types of manipulation of the neck may have been associated with injuries to arteries in the neck leading to or contributing to serious complications including stroke. Stroke caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of the complication ever occurring. If there is a casual relationship at all it is extremely rare and remote. The doctor will make every reasonable effort during the examination to screen for contraindications for care.

I have read/understand the included information and certify it to be true and accurate to the best of my knowledge.

_____

**PATIENT PRINTED NAME**

_____

**SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN (IF A MINOR)**

_____

**DATE**