NEW PATIENT HEALTH HISTORY FORM

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

TODAY'S DATE:

PATIENT DATA		
FIRST NAME:	LAST NAME:	DATE OF BIRTH:
EMAIL:	PHONE 1:	PHONE 2:
May we contact you via e-mail? ☐ YES ☐ NO		

ADDRESS:	CITY:	STATE:	ZIPCODE:
EMERGENCY CONTACT:		PHONE:	

CURRENT COMPLAINTS			
DESCRIBE INJURY OR SYMPTOMS:			
DATE OF INJURY OR DATE SYMPTOMS APPEARED:			
HAVE YOU EVER HAD THE SAME CONDITION? ☐ YES ☐ NO		IF YES, WHEN:	
DO YOU EXPERIENCE PAIN EVERYDAY?		☐ NO	☐ YES
DO YOUR SYMPTOMS INTERFERE WITH DAILY LIFE?		☐ NO	☐ YES
DOES YOUR PAIN WAKE YOU UP AT NIGHT?		☐ NO	☐ YES
ARE YOUR SYMPTOMS WORSE DURING CERTAIN TIMES OF DAY?		☐ NO	☐ YES
DO CHANGES IN WEATHER AFFECT YOUR SYMPTOMS?		☐ NO	☐ YES
WHAT ACTIVITIES AGGRAVATE YOUR SYMPTOMS?			

MEDICAL HISTORY
HAVE YOU BEEN TREATED FOR ANY CONDITION(S) IN THE LAST YEAR? ☐ NO ☐ YES
IF YES, PLEASE DESCRIBE:
DATE OF LAST PHYSICAL EXAM: IS THERE A CHANCE YOU MIGHT BE PREGNANT? ☐ YES ☐ NO
HAVE YOU HAD X-RAYS TAKEN? ☐ YES ☐ NO If YES, where:
WHAT MEDICATIONS ARE YOU CURRENTLY TAKING AND FOR WHAT CONDITIONS? (PLEASE LIST DOSAGE AND AMOUNTS)

WHAT VITAMINS, MINERALS, SUPPLEMENTS AND/OR HERBS DO YOU CURRENTLY TAKE? (PLEASE LIST ITEM, DOSAGE, FREQUENCY AND FOR WHAT CONDITION(S):

FAMILY HISTORY

Family Members – List present and past health conditions (examples: heart disease, cancer, stroke, diabetes arthritis, etc.)

Have you ever:	No	Yes	Briefly Explain:
Had broken bones?	☐	☐	
Been hospitalized?	☐	☐	
Been in an auto accident?	☐	☐	
Had sprains / strains?	☐	☐	
Been struck unconscious?	☐	☐	
Had surgery?	☐	☐	

HABITS (Please place an "x" in appropriate box")	NONE	LIGHT	MODERATE	HEAVY
ALCOHOL	☐	☐	☐	☐
COFFEE	☐	☐	☐	☐
TOBACCO	☐	☐	☐	☐
DRUGS	☐	☐	☐	☐
EXERCISE	☐	☐	☐	☐
SLEEP	☐	☐	☐	☐
APPETITE	☐	☐	☐	☐
SOFT DRINKS	☐	☐	☐	☐
WATER	☐	☐	☐	☐
SALTY FOODS	☐	☐	☐	☐
SUGARY FOODS	☐	☐	☐	☐
ARTIFICIAL SWEETENERS	☐	☐	☐	☐

SIGNATURES

NAME OF 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 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: _____

SPOUSE OR GUARDIAN SIGNATURE: _____ DATE: _____

Have you ever suffered from any of the following?

- ☐ 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
- ☐ Venereal Disease
- ☐ Other

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

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