

Health History Information

Welcome to our office- we are glad you chose chiropractic to take care of your health needs.

Today's Date: _____ Patient # _____

Your Name (please print): _____ Home: _____

Address: _____ Work: _____

Birth Date: _____ E-Mail: _____ Cell: _____

Your Occupation: _____ Employer: _____

Spouse: _____ Emergency contact: _____ Phone: _____

Who may we thank for referring you to our office? _____

Have you ever been to a chiropractor before? No Yes Dr. _____

Were you pleased with his care? Yes No _____

What type of treatments he did for you: _____

Do you have any friends or relatives that see chiropractors? Yes No

Tell Us About Your Condition

What is the main health concern you have today? _____

Do you feel: Pain Stiffness Swelling Numbness/Tingling

Describe what the pain feels like: Sharp Dull Soreness Throbbing

Is the pain: Improving Getting worse Staying the same

How often does the neck pain occur: Constant Intermittent _____

How long has it been bothering you? _____

On a scale of 1-10 (1 least, 10 most), rate the severity of your pain:

(no pain) 1 2 3 4 5 6 7 8 9 10 (most severe)

What activities make the pain worse? _____

Does the pain interfere with your: Work Sleep Exercise Daily Activities

What have you done to make it feel better? _____

What do you think is the cause of this condition? _____

What other conditions would you like us to help you with? _____

Does anyone in your family have similar problems like the ones you have? _____

Were these similar complaints the result of a previous accident? Yes No Don't Know

If yes, please describe when the accident(s) occurred and what injuries you had: _____

What other doctors have you seen for this condition?

Dr. Name: _____ Date: _____

Did they do any special tests? X-Rays MRI CT Scan Blood test

Treatment received: Prescribed Medication(s) _____

Referred you to see another Dr: _____ Other: _____

Please list all **medications** you are presently taking, what they are for and how often you take them:

1. _____

2. _____

3. _____

Please list all **vitamins/supplements** you are presently taking, and how often you take them:

1. _____

2. _____

3. _____

Have you had any other serious accidents that required medical care? Yes No

Describe: _____

Have you had any serious illnesses that required hospitalization? Yes No

Describe: _____

Have you had any surgeries? Yes No _____

Have you broken any bones in your body? Yes No _____

Have you been diagnosed with any of these conditions:

- Cancer Type: _____ Treatment: _____
- Diabetes Type: _____ Treatment: _____
- Heart Problem: _____ Treatment: _____
- High Blood Pressure- Last reading: _____
- Stroke Seizures Chest Pain Other _____
- Asthma _____ Allergies _____
- Digestive Problems _____ Heartburn Gas/Bloating Constipation/Diarrhea
- Recent Illness _____ Fever Nausea/Vomiting Dizziness
- Head injuries Concussion Knocked unconscious _____
- Spinal Arthritis Disc Herniation Epidural Injection _____
- Other conditions: _____

Are you pregnant? Yes No Maybe- my last period was: _____

Have you ever had an epidural / cortisone injection? No Yes _____

The above is accurate to the best of my knowledge

Signature	Print Name	Date
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Financial Responsibility

Who is responsible for payment? _____

How would you like to pay for your care? Cash Check Credit Card

I give permission for this office to charge my credit card for any future balances owed.

Credit Card # _____ Expiration: _____

Signed _____ Print Name _____

I would like to see if my insurance company will pay for some of my chiropractic care.

Ins Company: _____ Policy: _____ Group: _____

I understand that my insurance plan will not pay for the total amount of the charges for chiropractic services and that I will be responsible for any payments not covered by my insurance company. This includes deductibles, co-payments, co-insurance payments and any fees that are not covered by my insurance plan.

Signature	Print Name	Date
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