Health History Information

Patient #_______________

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

Today's Date: ________________ Home Phone:______________________

Name (print):____Cell Phone:________________________

Address:______________________________________City:___________________Zip:_____________

Birth Date:___________________Age_____________SS#:______________________________________

Email Address:____

Employer:_____________________________________Work Phone:____________________________

Marital Status: ❒ Single ❒ Married Spouse name:__________________ ❒ Divorced

Children's Names and Ages:____

Emergency contact:_______________________Relation:_______________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- Why? ___________________________________

What type of treatments did he do for you:____

Tell Us About Your Condition

What is your main health concern you have today?____

When did the onset of your condition begin?____

Is your condition: ❒ Improving ❒ Getting worse ❒ Staying the same

Do you feel: ❒ Pain ❒ Stiffness ❒ Swelling ❒ Numbness/Tingling ❒ ____________

Describe what the pain feels like: ❒ Sharp ❒ Dull ❒ Soreness ❒ Throbbing

How often does the pain occur: ❒ Constant ❒ Comes and Goes _______________________

On a scale of 1-10 (with 0=no pain), rate the severity of your pain____________________________

Does your condition 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 health concerns would you like us to help you with?________________________

____

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

Are your present 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 your present condition?

Dr. Name:________________________________Date:________________

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

❐ Medication(s) Prescribed: ____

❐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 health issues that required medical care? ❐Yes ❐No

Describe:____

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

Describe:____

Have you had any surgeries? ❐No ❐Yes ________________________________

Have you ever broken any bones in your body? ❐No ❐Yes ____________________

Have you been diagnosed with any of these conditions:

❒ Cancer Type:________________________________Treatment:______________________

❒ Diabetes Type:_______________________________Treatment:______________________

❒ Heart Problem:________________________________Treatment:______________________

❒ High Blood Pressure- Last known reading:_______________________________________

❒ Stroke ❒ Seizures ❒ Chest Pain ❒ Other__________________________________

❒ Asthma ______________________ ❒ Allergies ___________________________________

❒ Digestive Issues_________________ ❒ 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**

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**