New Patient Health History

Please answer the following as completely as possible. Use the back of the forms if you need additional space. All information is kept strictly confidential.

Patient Data

Name______________________________ Date________ E-Mail_____________________

Address___________________________ City________________ State___ Zip_________

Phone (please circle best #) _______________(work) ______________(home) _____________(cell)

Date of Birth____________ Age_____ Marital Status ____ Number of Children_____

Occupation________________________ Employer________________________________

Spouse's Name____________________ Emergency Contact______________________

Emergency Contact Phone______________________________

Insurance Information

Nature of Injury (please circle) *Automobile** Work Other

Do you have health insurance? Yes No Name of Insured______________________

(If yes, please provide us with your card(s) so that we may make a photocopy.)

**Please complete the following if this is related to an automobile accident:*

Auto insurance company______________________ Claim #________________________

Contact Person_______________________________ Phone________________________

I understand and agree that insurance policies are arrangements between insurance carriers and me, and I acknowledge that all services rendered and charged to me are my personal responsibility.

Patient's signature_______________________________________ Date______________

Signature of Parent or Guardian___________________________ Date______________

Current Complaints

Please describe:____

____

Date of Injury_________ Ever had this problem before? No Yes If yes, when?________

____

Ever had treatment elsewhere for this condition?_________________________________

What makes your pain better?____

What makes it worse?____

Please describe what the pain feels like.___________________________________

Please indicate the severity of your symptoms:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Ever**

Is there time of day that your pain is better?_______________ Worse?_______________

Medical History

Have you been treated for any medical conditions in the past 5 years? Yes No

If yes, please list____

Please list any x-rays, MRIs or other tests that you have had in the past 5 years:

____

Please list any medications or supplements you are taking and reason(s) for taking them:

____

____

I am [RIGHT] [LEFT] handed. (Please circle one.)

			Please describe briefly.
Have you ever been hospitalized?	Yes	No	________________
Have you ever had surgery?	Yes	No	________________
Have you ever had an auto accident?	Yes	No	________________
Have you had any broken bones?	Yes	No	________________
Do you have any allergies?	Yes	No	________________

Have you recently experienced any change in weight?	Yes	No
Does the pain interfere with your ability to sleep?	Yes	No
Do you have pain every day?	Yes	No
Does pain wake you up at night?	Yes	No
Have you had changes in bowel, bladder or sexual functions?	Yes	No
Does your pain interfere with your daily activities?	Yes	No

If yes, please describe____

Please indicate any health conditions that members of your family have had/now have.

____

____

Habits

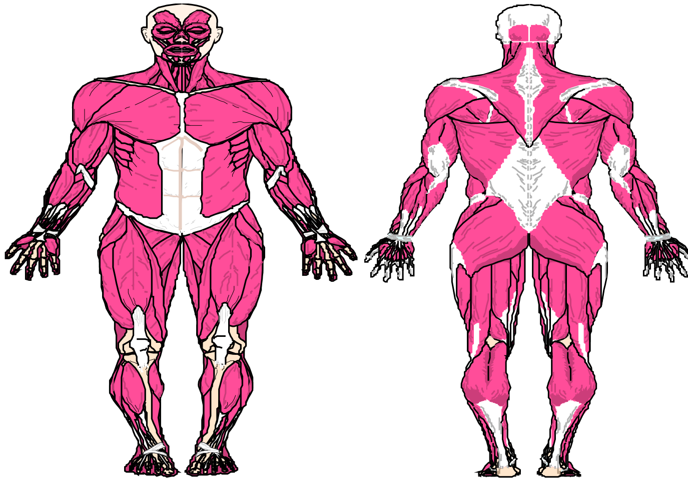
	How Often?
Exercise	____________________
Alcohol	____________________
Coffee	____________________
Soda	____________________
Sweets	____________________

Tobacco

Currently	Yes	No	Packs per day?_________	How many years?________
Previously	Yes	No	Packs per day?_________	How many years?________

Please use the symbols & drawings to show symptoms.

A=achy **B**=burning **N**=numbness **P**=pins/needles **S**=stabbing **Z**=other



Please circle any of the following conditions that you now have or have had in the past.

Allergies	Fatigue	Polio
Asthma	Frequent Urination	Prostate Trouble
Anemia	Headache	Sciatica
Arthritis	Hemorrhoids	Shortness of Breath
Atherosclerosis	High Blood Pressure	Sinus Infections
Back Pain	Hot Flashes	Sleep Problems
Bruising	Irregular Heartbeat	Scoliosis
Cancer	Kidney Infection	Stroke
Chest Pain	Kidney Stones	Swelling of Ankles
Cold hands/feet	Low Blood Pressure	Thyroid Problem
Depression	Loss of Smell	Tuberculosis
Diabetes	Loss of Taste	Ulcers
Digestion Problems	Lumps in the Breast	Varicose Veins
Dizziness	Neck Pain	Vision Problems
Dementia	Nervousness	Venereal Disease
Ringing in the Ears	Nosebleeds	Balance Problems
Eye Pain	Pacemaker	Multiple Sclerosis
Other:___________	Other:____________	Other:____________
Other:___________	Other:____________	Other:____________