NEW HEALTH CHIROPRACTIC

Personal and Family Health History

Name _____ Referred By _____

Date _____ Social Security# _____

Address _____ Occupation _____

City _____ State ____ Zip _____ Employer _____

Phone Home _____ Work _____ Cell _____

E-Mail _____ Marital Status S M D W

Date Of Birth _____ (Age _____) Spouse's Name _____

Number of Children _____ Spouse's Occupation _____

Please make sure all insurance information is on file and we have a current copy of your insurance card.
Insurance carrier _____ Relationship to insured: SELF SPOUSE CHILD OTHER
Emergency contact other than someone living with you _____

Current Health Condition

Present Complaint (reason for your visit today) _____

_____

Was this problem caused from an accident? Y N (If yes, briefly explain) _____
Pain or Problem started on _____
Pains are: □ Sharp □ Dull □ Constant □ Intermittent
What activities aggravate your condition/pain? _____
Is condition worse during certain times of the day? _____
Is this condition getting progressively worse? _____
Other Doctors seen for this condition _____
Have you ever had X-rays taken? Yes No When? _____ **Where?** _____
Have you ever had a MRI ? or CT scan? When? _____ **Where?** _____

***RECREATIONAL / EXERCISE*: Type:** _____ **Freq.** ____ **/wk; Duration** ____ **Min. / Hrs**

***SOCIAL HABITS* (Please circle appropriate responses and fill in the blank)**

TOBACCO: ____ **pk /** ____ **day, wk, for** ____ **yrs; Chew** ____ **yrs; Pipe** ____ **yrs CAFFEINE (SODA, COFFEE, TEA)** ____ **/day**

ALCOHOL ____ **glasses of wine, beer, mixed dr. /** ____ **day,** ____ **wk,** ____ **mo.; SLEEP INTERRUPTED?** ____ **x's / night for** ____ **mo,** ____ **yrs**

People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (relief of pain or discomfort (relief care) and others are interested in having the cause of the problem, as well as the symptoms corrected and relieved (corrective care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (comprehensive care). Your doctor will weigh your needs and desires when recommending your treatment. Please check the type of care desired……
Relief Care □ Corrective Care □ Comprehensive Care □ Doctor to select appropriate care for my condition □

_____ _____

Signature **Date**

PAST HISTORY

PREVIOUS INJURIES (MAV, WC, etc.)_____

_____

PREVIOUS TREATMENT HISTORY

DATE	DR/HOSP	TREATMENT	RESPONSE	TREATMENT DURATION	TEST(S)	TEST RESULT

PAST HOSPITALIZATION / ILLNESS _____

SURGICAL HISTORY _____

GENERAL STATE OF HEALTH _____

MEDICATIONS/VITAMINS_____

ALLERGIES _____

FAMILY HISTORY [1.FATHER, 2.MOTHER, 3.SISTER(a, b, etc) 4.BROTHER(a, b, etc)]

CANCER( )_____ ;DIABETES( ) _____ ; CARDIAC( )_____;BP( ) _____ ;STROKE( )_____

ARTHRITIS( )_____

OTHER _____

_____

REVIEW OF SYSTEMS

Please write in a number: 1 PRESENTLY HAVE; 2. PREVIOUSLY HAD; 3. RELATED TO ACCIDENT (Date: _____)

GENERAL
___Allergy
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep loss
___Weight loss
___Nervousness/depression
___Neuralgia
___Numbness
___Sweats
___Tremors

EYES, EARS, NOSE, THROAT
___Asthma
___Colds
___Sore throat
___Deafness
___Dental decay
___Earache/noises
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Failing vision
___Far sighted
___Gum trouble
___Hay fever
___Hoarseness
___Nasal obstruction
___Near sighted

MUSCULOSKELETAL
___Arthritis
___Bursitis
___Foot Trouble
___Hernia
___Low back pain
___Lumbago
___Neck pain/stiffness
___Shoulder blade pain
Pain or numbness in:
___ Shoulders
___ Arms
___ Elbows
___ Hands
___ Hips
___ Legs
___ Knees
___ Feet
___Painful tailbone
___Poor posture
___Sciatica
___Spinal curvature

GENITO-URINARY
___Bedwetting
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection or stones
___Painful urination
___Prostate trouble
___Pus in urine
___Painful menstruation
___Hot flashes
___Irregular cycle
___Lumps in breasts

CARDIOVASCULAR
___Hardening of arteries
___High blood pressure
___Low blood pressure
___Pain over heart
___Poor circulation
___Rapid heart beat
___Slow heart beat
___Swelling of ankles

RESPIRATORY
___Chest pain
___Chronic cough
___Difficult breathing
___Spitting up blood
___Spitting up phlegm
___Wheezing

GASTROINTESTINAL
___Belching or gas
___Colitis
___Colon trouble
___Constipation
___Diarrhea
___Difficult digestion
___Distention of abdomen
___Excessive hunger
___Gall bladder trouble
___Hemorrhoids
___Intestinal worms
___Jaundice
___Liver trouble
___Nausea
___Pain over stomach
___Poor appetite
___Vomiting
___Vomiting blood

OTHER:_____