



**About You**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
[ ] Male [ ] Female SS#: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
Ethnic Origin/Race: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt# \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Marital Status: S M D W # of Children: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
(If minor) Parent or Guardian: \_\_\_\_\_

**In case of an emergency, whom should we contact?**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name of your family doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Next appointment with your doctor: \_\_\_/\_\_\_/\_\_\_ May we contact your family doctor if needed? [ ] Yes [ ] No  
Who may we thank for referring you to our office: \_\_\_\_\_

**Insurance Information**

*We will make a copy of your insurance card(s). However, please complete the following information*

**Are you the policy holder? [ ] Yes [ ] No If YES, skip this section. If NO please complete next section.**

Insurance Name: \_\_\_\_\_ Insurance #: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Policy ID#: \_\_\_\_\_  
Birthdate: \_\_\_/\_\_\_/\_\_\_ [ ] Male [ ] Female Policyholder's SS# \_\_\_\_\_  
Address: \_\_\_\_\_ Employer: \_\_\_\_\_

**Do you have secondary insurance coverage? [ ] Yes [ ] No If YES, please complete the next section.**

Insurance Name: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Insurance #: \_\_\_\_\_  
Birthdate: \_\_\_/\_\_\_/\_\_\_ [ ] Male [ ] Female Policyholder's SS# \_\_\_\_\_  
Address: \_\_\_\_\_ Employer: \_\_\_\_\_

**We reserve the right to collect a \$35 fee for cancellations with less than 24 hours notice. Initial: \_\_\_\_\_**

**Assignment & Release**

\*I understand that health & accident insurance policies are an agreement between an insurance carrier & myself. Furthermore, I understand that this office will prepare any necessary reports & forms to assist me in making collection from the carrier & that any amount authorized to be paid directly to this doctor's office will be credited to my account upon receipt.  
\*As a courtesy to you we will verify your health care benefits for this office. You will then be responsible for any co pays and deductibles.  
\* Your health insurance is a contract between you & the insurance carrier. In the "rare" event that your insurance company is in "bad faith" & after our office has made every attempt to have all claims paid, we will have you, the patient be responsible for contacting your insurance carrier to have the claims paid.  
\*If your insurance company has not paid within 120 days of billing, then you will be responsible to pay the balance due.  
\*If Collection efforts become necessary to enforce payment terms, the patient agrees to pay all collection costs, attorney's fees, & other costs associated with collecting this balance.  
\* I hereby authorize & release the doctor & whomever he/she assistants, to administer treatment, physical examination, x-rays studies, chiropractic care, physical therapy of any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all of any part of my patient record to any person of corporation which is or may be liable under a contract to this office to a patient of a family member of or employer of the patient for all of part of the clinic's charge, including & not limited to hospital or medical service companies, worker's compensation carrier, welfare funds, or the patient's employer.

**Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_**

# New Patient Health History Form

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

## Patient Data

First Name  Last Name  Date  Email\*

\* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

## Mailing address

Address  City  State  Zip

Telephone (Work)  (home)  Referred By

Age  Birth Date  Social Security #  Number of Children

Occupation  Employer

Marital Status  Spouse's Name  Spouse's Occupation

Spouse's Employer  Spouse's Health Status

Emergency Contact  Phone

## Current Complaints

Nature of Injury:  Automobile\*  Work  Other

Please describe:

Date of Injury  Date symptoms appeared

Have you ever had same condition?  No  Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care?  No  Yes

If yes, please describe

## Insurance Information

Name of party responsible for payment  Phone

Do you have health insurance?  No  Yes Name of company

**\* If an auto accident, please provide:**

Insurance Company Name  Contact Person

Phone:  Claim #

## Signatures

Name of the 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's or guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

## Medical History

Have you been treated for any conditions in the last year?  No  Yes

If yes, please describe

Date of last physical exam  Is there a chance that you are pregnant?  No  Yes

Have you had X-rays taken?  No  Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc.)

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had surgery?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

## Family History

**Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)**

Do you experience pain every day?	<input type="radio"/> No	<input type="radio"/> Yes
Do your symptoms interfere with daily life?	<input type="radio"/> No	<input type="radio"/> Yes
Does pain wake you up at night?	<input type="radio"/> No	<input type="radio"/> Yes
Are your symptoms worse during certain times of the day?	<input type="radio"/> No	<input type="radio"/> Yes
Do changes in weather affect your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
Do you wear orthotics?	<input type="radio"/> No	<input type="radio"/> Yes
Do you take vitamin supplements?	<input type="radio"/> No	<input type="radio"/> Yes
What activities aggravate your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes

Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Have you ever suffered from:**

- 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**=Ache                      **O**=Other  
**B**=Burning                  **P**=Pins & Needles  
**N**=Numbness                **S**=Stabbing

