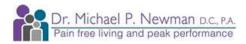


New Patient Health History Form

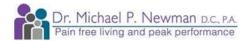
In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

| Patient Data | | | | | |
|--|----------------------------------|--|------------------------------|-----------------------|--|
| First Name | Last Name | Date | Email* | | |
| * Your em | nail will NOT be shared with any | 3d parties, and is used for oc | ccasional office announce | ments and promotions. | |
| | | | | - | |
| Mailing address | | | | | |
| Address | | City | State | Zip | |
| Telephone (Work) | (hom | | Referred By | | |
| Age Birth Do | social 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 Complain | nte. | | | | |
| | | | | | |
| Au Au | tomobile* | Other | | | |
| Please describe: | | | | | |
| Date if Injury | Date symptoms appea | red | | | |
| Have you ever had same condition? O No O Yes If yes, when? | | | | | |
| List of other practitioners seen for this injury/condition | | | | | |
| | nder chiropractic care? O No | ○ Yes | | | |
| If yes, please describe | | | | | |
| | | | | | |
| Insurance Inform | ation | | | | |
| Name of party responsi | ble for payment | | Phone | | |
| | | e of company | 1110110 | | |
| * If an auto accident, p | lease provide: | | | | |
| Insurance Company No | | Contact Person | | | |
| Phone: | Claim # | | | | |
| | | | | | |
| Signatures | | | | | |
| Name of the insure | ed | | | | |
| | I understand and agree that h | nealth/accident insurance policie | | | |
| | responsibility for timely paym | agree that all services rendere ent. I understand that if I susp | end or terminate my care/tre | | |
| Patient's signature | | d to me will be immediately due | e and payable. _ Date | | |
| | an's signature | | | | |
| | J - | | _ | | |



| Medical History | | | | | | |
|--|--|------------|----------------|---------------|--------------------|-------|
| Have you had X-rays taken? O No O Yes If Yes What medications are you taking and for what conditions | re a chance s, where? ions (Please | list dosag | are pregnant | ts, etc)I |) Yes | |
| What vitamins, minerals, or herbs do you currently take | Please lis | | | osage, and fr | equency). | |
| Have you ever: Broken bones? Been hospitalized? Been in an auto accident? Had Sprains/Strains? Been struck unconscious? Had surgery? | 000000 | Diferily | Explain | | | |
| Family History Family Members - Present and past health condi | tions (Exan | nple: he | art disease, c | cancer, diab | etes, arthritis, a | etc.) |
| Do you experience pain every day? Do your symptoms interfere with daily life? Does pain wake you up at night? Are your symptoms worse during certain times of Do changes in weather affect your symptoms? Do you wear orthotics? Do you take vitamin supplements? What activities aggravate your symptoms? | the day? | | | | 00000 | ~ ~ ~ |
| Habits | | | None | Light | Moderate | Heavy |
| Alcohol Coffee | | | 8 | 8 | 8 | 8 |

| Habits | None | Light | Moderate | Heavy |
|-----------------------|------|-------|----------|-----------|
| Alcohol | 0 | 0 | 0 | \circ |
| Coffee | | | | \bowtie |
| Tobacco | | | | \vdash |
| Drugs | lö | l Κ | l Ö l | Ŏ |
| Exercise | ΙÖ | ΙÖ | l Ö l | Ŏ |
| Sleep | ΙÖ | ΙÖ | l Ö l | Ŏ |
| Appetite | | | | O |
| Soft Drinks | | | | 0 |
| Water | | | | 0 |
| Salty Foods | l Q | I O | 1 Q | Q |
| Sugary Foods | l Q | l Q | l Q l | Q |
| Artificial Sweeteners | | | | O |



| Have you ever suffered from: | |
|--|--|
| Alcoholism | Please use the following letters to indicate TYPE and |
| Allergies | LOCATION of the symptoms you currently are experiencing. |
| Anemia | |
| Arteriosclerosis | A =Ache O =Other |
| Arthritis | B=Burning P=Pins & Needles |
| Asthma | N =Numbness S =Stabbing |
| Back Pain | J |
| Breast Lump | |
| Bronchitis | 86 |
| Bruise Easily | |
| | |
| Chest Pain/Conditions | |
| Cold Extremities | |
| | |
| | |
| | |
| Depression Digital and a second secon | |
| Diabetes Diabetes | |
| Digestion Problems | |
| Dizziness | |
| Ears Ring | |
| Excessive Menstruation | |
| Eye Pain or Difficulties | |
| _ Fatigue | |
| Frequent Urination | |
| | ווער עוגו ווער עוגו |
| ☐Hemorrhoids | |
| ☐High Blood Pressure | |
| ☐Hot Flashes | |
| □rregular Heart Beat | |
| ☐rregular 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 | |
| | |
| 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: | |