**Spinal Care New Patient Health History Form**

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

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| **Patient Data** |
| First Name: Enter Here  | Last Name: Enter Here |
| Today’s Date: Enter Here | Date of Birth: Enter Here Age: Enter Here |

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| **Contact Information** |
| Street Address: Enter Here City: Enter Here State: Click Here to Select Zip Code: Enter HereEmail Address: Enter Here Cell Phone: Enter Here Home Phone: Enter Here   |
| Referred by: Enter Here Emergency Contact/Relationship: Enter Here Emergency Contact Phone #: Enter Here |
| Occupation: Enter Here Employer: Enter HereMarital Status: Click Here to Select Spouse’s Name: Enter Here Spouse’s Health Status: Enter Here Spouse’s Occupation: Enter Here Spouse’s Employer: Enter Here  |
| \*Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions. |

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| **Current Complaints** |
| Nature of Injury: [ ]  Automobile [ ]  Work [ ]  Other Please describe: Enter Here Date of injury: Enter Here Date symptoms appeared: Enter HereHave you ever had the same condition? [ ]  Yes [ ]  No If yes, when? Enter HereList of other practitioners seen for this injury/condition. Enter Here Have you ever been under chiropractic care? [ ]  Yes [ ]  No If yes, when? Enter Here If yes, please describe: Enter Here |

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| **Insurance Information** |
| Name of party responsible for payment: Enter Here Phone: Enter Here Do you have health insurance? Yes [ ]  No [ ]  If yes, what is the name of the insurance company? Enter Here |
| **\*If an auto accident, please provide:** |
| Insurance Company Name: Enter Here Contact Person: Enter HereCompany Phone Number: Enter Here Claim #: Enter Here |

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| **Signatures** |
|  Enter Here 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 or professional services rendered to me will be immediately due and payable. Patient’s signature Date: Parent/Guardian’s Signature Date: (If applicable) |

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| **Medical History** |
| Have you been treated for any conditions in the last year? Yes [ ]  No [ ]  If yes, please describe: Enter HereDate of last physical exam: Enter Here Is there a chance that you are pregnant? Yes [ ]  No [ ]  Have you had X-rays taken? Yes [ ]  No [ ]  If yes, where? Enter Here What medications are you taking and for what conditions? (Please list dosage and amounts, etc.) Enter Here What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency) Enter Here  |

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| **Have you ever:** | **Yes** | **No** | **Briefly explain** |
| Broken bones? |[ ] [ ]  Enter Here  |
| Been hospitalized? |[ ] [ ]  Enter Here  |
| Been in an auto accident? |[ ] [ ]  Enter Here  |
| Had sprains/strains? |[ ] [ ]  Enter Here  |
| Been struck unconscious? |[ ] [ ]  Enter Here  |
| Had surgery? |[ ] [ ]  Enter Here  |
| Do you have an implantable device? |[ ] [ ]  Enter Here  |

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| **Family History** |
| Family Members – present and past health conditions (example: heart disease, cancer, diabetes, arthritis, etc.)Enter Here |
|  | **Yes** | **No** |
| 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 the day? |[ ] [ ]
| Do changes in weather affect your symptoms? |[ ] [ ]
| Do you wear orthotics? |[ ] [ ]
| Do you take vitamin supplements? |[ ] [ ]
| What activities aggravate your symptoms? Enter Here  |

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| **Habits** | **None** | **Light** | **Moderate** | **Heavy** |
| Alcohol |[ ] [ ] [ ] [ ]
| Coffee |[ ] [ ] [ ] [ ]
| Tobacco |[ ] [ ] [ ] [ ]
| Drugs |[ ] [ ] [ ] [ ]
| Exercise |[ ] [ ] [ ] [ ]
| Sleep |[ ] [ ] [ ] [ ]
| Appetite |[ ] [ ] [ ] [ ]
| Soft Drinks |[ ] [ ] [ ] [ ]
| Water |[ ] [ ] [ ] [ ]
| Salty Foods |[ ] [ ] [ ] [ ]
| Sugary Foods |[ ] [ ] [ ] [ ]
| Artificial Sweeteners |[ ] [ ] [ ] [ ]

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| **Smoking Status** |
| [ ]  Never smoker |
| [ ]  Former smoker  | [ ]  Smoker, current status unknown |
| [ ]  Current every day smoker | [ ]  Current some days smoker |
| [ ]  Heavy tobacco smoker | [ ]  Light tobacco smoker |

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| **Allergies (Please list.)** | **Very Mild** | **Mild** | **Moderate** | **Severe** |
| Medication/Drugs: Enter Here  | [ ]  | [ ]  | [ ]  | [ ]  |
| Food: Enter Here  | [ ]  | [ ]  | [ ]  | [ ]  |
| Environmental: Enter Here  | [ ]  | [ ]  | [ ]  | [ ]  |
| Do you have any skin sensitivities? If so, please list: Enter Here  | [ ]  | [ ]  | [ ]  | [ ]  |

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| **Demographics** |
| Ethnicity: [ ]  Hispanic or Latino [ ]  Not Hispanic or Latino [ ]  Decline to Answer |
| Race: [ ]  White [ ]  American Indian or Alaska Native  [ ]  Asian [ ]  African American or Black  [ ]  Native Hawaiian or other Pacific Islander [ ]  Decline to Answer |
| Preferred Language: Enter Here  |

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| **Have you ever suffered from:** |
|  [ ] Alcoholism |  [ ]  Ears Ring |  [ ]  Nervousness |
|  [ ] Allergies |  [ ]  Excessive Menstruation  |  [ ]  Nosebleeds |
|  [ ]  Anemia |  [ ]  Eye Pain or Difficulties |  [ ]  Pacemaker |
|  [ ]  Ateriosclerosis  |  [ ]  Fatigue |  [ ]  Polio |
|  [ ]  Arthritis |  [ ]  Frequent Urination |  [ ]  Poor Posture |
|  [ ]  Asthma |  [ ]  Headache |  [ ]  Prostate Trouble |
|  [ ]  Back Pain |  [ ]  Hemorrhoids |  [ ]  Sciatica |
|  [ ]  Breast Lump |  [ ]  High Blood Pressure |  [ ]  Shortness of Breath |
|  [ ]  Bronchitis |  [ ]  Hot Flashes |  [ ]  Sinus Infections |
|  [ ]  Bruise Easily |  [ ]  Irregular Heart Beat |  [ ]  Sleep Problems or Insomnia |
|  [ ]  Cancer |  [ ]  Irregular Cycle |  [ ]  Spinal Curvatures |
|  [ ]  Chest Pain/Conditions |  [ ]  Kidney Infection |  [ ]  Stroke |
|  [ ]  Cold Extremities |  [ ]  Kidney Stones |  [ ]  Swelling of Ankles |
|  [ ]  Constipation |  [ ]  Loss of Memory |  [ ]  Swollen Joints |
|  [ ]  Cramps |  [ ]  Loss of Balance |  [ ]  Thyroid Condition |
|  [ ]  Depression |  [ ]  Loss of Smell |  [ ]  Tuberculosis |
|  [ ]  Diabetes |  [ ]  Loss of Taste |  [ ]  Ulcers |
|  [ ]  Digestion Problems |  [ ]  Lumps In Breast |  [ ]  Varicose Veins |
|  [ ]  Dizziness |  [ ]  Neck Pain or Stiffness  |  [ ]  Venereal Disease |
|  [ ]  Other: Enter Here |

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| 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 and Needles****N = Numbness S = Stabbing** |
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