Health History

Name_____Age_____Birth Date_____

Address_____ City_____State_____Zip_____

Cell_____Cell Provider_____

Home_____Work _____

Email_____

Occupation _____ Employer _____

Marital Status (Circle One): S M W D How Many Children _____

Name of Spouse _____ Phone Number_____

Occupation _____Employer _____

Other Emergency Contact _____ Relation_____

Phone Number _____Who Referred You to Our Office_____

Previous Chiropractic Care? ○ Yes ○ No If so, By Whom? _____

For What? _____ When? _____ X-rays taken? ○ Yes ○ No

Is your condition due to an accident? ○ Yes ○ No If yes: ○ Auto ○ Home ○ Leisure ○ Sports

Other _____

1st Complaint: What is bothering you? _____

How long has this been bothering you? _____

What makes you feel worse? _____

What makes you feel better? _____

What does it feel like? _____

Does it radiate? If so where?_____

How often does it bother you? _____

Describe any previous treatment. _____

2nd Complaint: What is bothering you? _____

How long has this been bothering you? _____

What makes you feel worse? _____

What makes you feel better? _____

What does it feel like? _____

Does it radiate? If so where?_____

How often does it bother you? _____

Describe any previous treatment. _____

3rd Complaint: What is bothering you? _____

How long has this been bothering you? _____

What makes you feel worse? _____

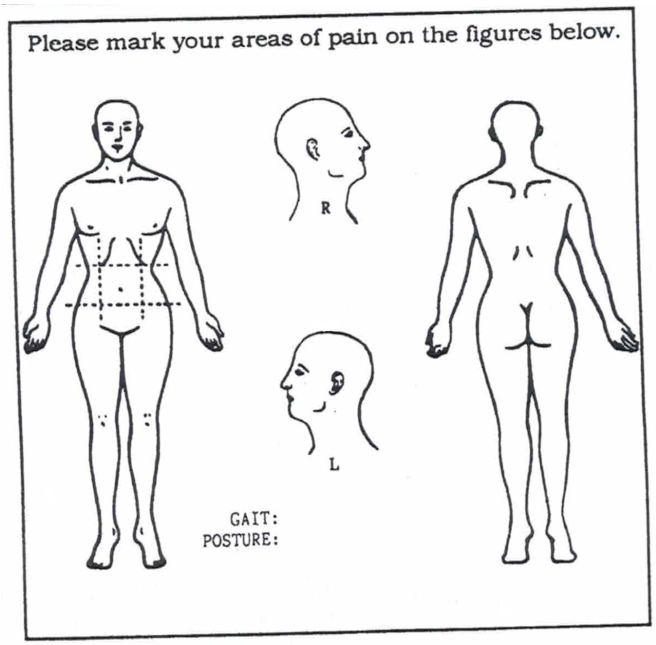
What makes you feel better? _____

What does it feel like? _____

Does it radiate? If so where? _____

How often does it bother you? _____

Describe any previous treatment. _____



Circle current conditions… Check former conditions:

HEAD AND NECK AREA

Headaches	Stiff Neck	Neck Pain	
Poor Posture	Light sensitivity	Tension	Sinus Disorder
Restricted Neck Movement	Zig Zag Flashes	High Blood Pressure	Head Colds
Nervousness	Nausea	Tremors	Sore Throat
Personality change	Eye or sinus pain	Insomnia	Hoarseness
Hayfever/allergies	Facial spasms	Dizziness	HIV positive (AIDS)
Skin disorder	Anxiety	Vertigo	Visual disturbances
	Irritability	Earache L R	

UPPER BACK AREA

Shoulder pain - front - back	Asthma	Numbness/tingling -	Chronic cough
Upper back pain	Sore aching muscles -	in the arms/hands L R	Spitting up phlegm/blood
Arm Pain L R	in the shoulders	Pain around collar bone	Difficulty breathing
Swollen joints/arms/hands L R	Chest colds	Joint stiffness/pain -	Elbow Pain
Arthritis	Thyroid condition	in arms/hands L R	Wrist Pain
Restricted Movement -	Respiratory disorder	Rapid Beating Heart	Hand Pain
in the shoulder/arm L R	Hot/cold spots in the		
	arm/hand L R	Slow beating heart	

MID BACK AREA

Middle back pain	Abdominal pain	Liver disorder	Tiredness
Scoliosis	Gallbladder problems	Fevers	Hiatal hernia
Chest pain	Jaundice	Low blood pressure	Heart Attack
Pain below breast bone	Shingles	Stomach disorder	Kidney Disorder
Restricted movement mid-back	Gas/heartburn/gastritis	Food allergies	
	Rib cage pain	Psoriasis	

LOW BACK AND PELVIS

Low back pain	Upper leg pain L R	Numbness/tingling-	Prostatitis
Painful tailbone	Lower leg pain L R	legs/feet L R	Leg Cramps
Hip pain	Foot pain L R	Diarrhea	Diverticulitis
Sciatica	Hernia	Constipation	Impotence
Colitis	Knee pain L R	Buttock pain	Hemorrhoids
Swollen joints- leg/foot L R	Cramping	Varicose veins	Change in urination
Restricted movement- leg/foot	Irregular/painful periods	Cold feet	Poor circulation
L R	Hot/cold spots-		
	legs/feet L R		

Other health symptoms: _____

_____

Describe any family health problems (parents, spouse, children):

_____

_____

List any surgeries you have had and the dates.

1. _____
2. _____
3. _____

List any medications you are taking (including over the counter and vitamins).

1. _____
2. _____
3. _____

List any accidents in which you received injuries and dates (car, slips/falls, work, etc.).

1. _____
2. _____
3. _____

List serious illnesses you have had and dates diagnosed (cancer, heart attack, stroke, infections, etc.).

1. _____
2. _____
3. _____

List leisure activities:

Sedentary	Strenuous
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Are you pregnant? ○ Yes ○ No Do you wear dentures? ○ Yes ○ No
Date of last menstruation cycle: _____
Date of last physical exam: _____ By whom? _____
Does anyone else in your family suffer from this or a similar condition? ○ Yes ○ No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that New Palestine Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to New Palestine Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____