

NEW PATIENT HEALTH HISTORY FORM

In order to provide you the best possible chiropractic care, please complete this form in its entirety.
All information is strictly CONFIDENTIAL.

PATIENT DATA

NAME _____ DATE _____ EMAIL _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK _____ CELL _____ BIRTH DATE _____
AGE _____ SOCIAL SECURITY # _____ MARITAL STATUS _____ # CHILDREN _____
OCCUPATION _____ EMPLOYER _____
EMERGENCY CONTACT _____ PHONE _____

CURRENT COMPLAINTS

PLEASE DESCRIBE _____

NATURE OF INJURY: AUTOMOBILE ACCIDENT _____ WORK INJURY _____ OTHER _____

DATE OF INJURY: _____ DATE SYMPTOMS APPEARED _____

HAVE YOU EVER HAD SAME CONDITION? ___NO___ YES IF YES, WHEN? _____

LIST OTHER PRACTITIONERS SEEN FOR THIS INJURY/CONDITION _____

INSURANCE INFORMATION-Please provide insurance card to be photocopied

DO YOU HAVE INSURANCE? ___YES___ ___NO___ NAME OF COMPANY _____

ID# _____ GROUP# _____ NAME OF RESPONSIBLE PARTY _____

**If due to an auto accident/work related injury please provide:

INSURANCE COMPANY NAME _____ ADJUSTER: _____

PHONE _____ CLAIM # _____

MEDICAL HISTORY

DATE OF LAST PHYSICAL EXAM _____ ARE YOU PREGNANT? ___NO___ ___YES___

CONDITIONS BEING TREATED FOR & /MEDICATIONS, VITAMINS, HERBS CURRENTLY TAKING _____

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, any fees for professional services rendered to me will be my responsibility.

PATIENT/GUARDIAN'S
SIGNATURE _____

DATE _____