

New Patient Health History

Please answer the following as completely as possible. Use the back of the forms if you need additional space. All information is kept strictly confidential.

Patient Data

Name _____ Date _____ E-Mail _____

Address _____ City _____ State ____ Zip _____

Phone (please circle best #)

Home: _____ Cell: _____ Work: _____

Date of Birth _____ Age _____ Marital Status _____ Number of Children _____

Occupation _____ Employer _____

Spouse's Name _____ Emergency Contact _____

Emergency Contact Phone Number(s) _____

How did you hear about us? _____

Name & Address of Primary Care Physician _____

Insurance Information

Nature of Injury (please circle) *Automobile** Work Other

Do you have health insurance? Yes No

(If yes, please provide us with your card(s) so that we may make a photocopy.)

Name of Insured _____ Date of Birth _____

**Please complete the following if this is related to an automobile accident:*

Auto insurance company _____ Claim # _____

Contact Person _____ Phone _____

I understand and agree that insurance policies are arrangements between insurance carriers and me, and I acknowledge that all services rendered and charged to me are my personal responsibility.

Patient's signature _____ Date _____

Signature of Parent or Guardian _____ Date _____

Current Complaints

Please describe: _____

Date of Injury _____ Ever had this problem before? Yes No If yes, when? _____

Have you been treated elsewhere for this condition? Yes No

If yes, please describe. _____

What makes your pain better? _____

What makes it worse? _____

Please describe what the pain feels like. _____

Please indicate the severity of your symptoms:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Ever

If there is there time of day that your pain is worse, please indicate: _____

Medical History

Have you been treated for any medical conditions in the past 5 years? Yes No

If yes, please list _____

Please list any x-rays, MRIs or other tests that you have had in the past 5 years:

Please list any medications or supplements you are taking and reason(s) for taking them:

I am [RIGHT] [LEFT] handed. (Please circle one.)

Please describe briefly.

Have you ever been hospitalized?	Yes	No	_____
Have you ever had surgery?	Yes	No	_____
Have you ever had an auto accident?	Yes	No	_____
Have you had any broken bones?	Yes	No	_____
Do you have any allergies?	Yes	No	_____

Have you recently experienced any change in weight? Yes No

Does the pain interfere with your ability to sleep? Yes No

Do you have pain every day? Yes No

Does pain wake you up at night? Yes No

Have you had changes in bowel, bladder or sexual functions? Yes No

Does your pain interfere with your daily activities? Yes No

If yes, please describe _____

Please indicate any health conditions that members of your family have had/now have.

Habits

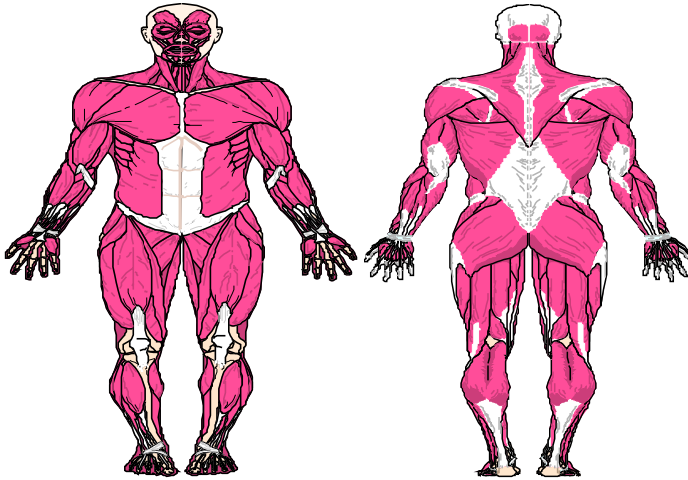
How Often?

Exercise _____
 Alcohol _____
 Coffee _____
 Soda _____
 Sweets _____
 Tobacco _____

Currently Yes No Packs per day? _____ How many years? _____
 Previously Yes No Packs per day? _____ How many years? _____

Please use the symbols & drawings to show symptoms.

A=achy **B**=burning **N**=numbness **P**=pins/needles **S**=stabbing **Z**=other



Please circle any of the following conditions that you now have or have had in the past.

- | | | |
|----------------------|---------------------|---------------------|
| Allergies | Fatigue | Polio |
| Asthma | Frequent Urination | Prostate Trouble |
| Anemia | Headache | Sciatica |
| Arthritis | Hemorrhoids | Shortness of Breath |
| Atherosclerosis | High Blood Pressure | Sinus Infections |
| Back Pain | Hot Flashes | Sleep Problems |
| Bruising | Irregular Heartbeat | Scoliosis |
| Cancer | Kidney Infection | Stroke |
| Chest Pain | Kidney Stones | Swelling of Ankles |
| Cold hands/feet | Low Blood Pressure | Thyroid Problem |
| Depression | Loss of Smell | Tuberculosis |
| Diabetes | Loss of Taste | Ulcers |
| Digestion Problems | Lumps in the Breast | Varicose Veins |
| Dizziness | Neck Pain | Vision Problems |
| Dementia | Nervousness | Venereal Disease |
| Ringling in the Ears | Nosebleeds | Balance Problems |
| Eye Pain | Pacemaker | Multiple Sclerosis |
| Other: _____ | Other: _____ | Other: _____ |
| Other: _____ | Other: _____ | Other: _____ |