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.

Patient Data

First Name ______ Last Name ______ Date ______ Email* ______

*Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Are you on social media? Yes ☐ No ☐ Can we request to follow you? Yes ☐ No ☐

What is your Facebook Name? ______ Like our page, Centre for Healing Arts @ Limerick

Mailing Address

Address ______ City ______ State ______ Zip ______

Telephone (Cell) ______ (Home) ______ Referred By ______

Age ______ Birth Date ______ 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 (Cell) ______ (Home) ______

Current complaints, please describe why you are here today.

Cause of Chief Complaint: ☐ Automobile* ☐ Work ☐ Other

Please Describe: ______

Date of injury ______ Date symptoms appeared ______

Have you ever had same condition? ◯ No ◯ Yes If yes, when? ______

List of other practitioners seen for this injury/condition ______

Have you ever been under chiropractic care? ______

If yes, please describe ______

Insurance Information

Do you have health insurance? ◯ No ◯ Yes Name of Company ______

Primary Care Physician Office ______ Doctor's Name ______

Signatures

Name of insured ____

I understand and agree that health/accident insurance policies are an arrangement between and 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 for professional services rendered to me will be immediately due and payable.

Patients Signature ________________________________ Date ________________

Spouse's or Guardian's Signature ________________________________ Date ________________

Medical History

Have you been treated for any conditions in the last year? ◯ No ◯ Yes

If yes, please describe

Date of last physical exam   Is there a chance that you are pregnant? ◯ No ◯ Yes

Have you had X-rays taken? ◯ No ◯ Yes   If Yes, where?

What medications are you taking and for what conditions? (Please list dosage and amounts, etc.)

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever...	No	Yes	Briefly Explain
Broken bones?	◯	◯	
Been hospitalized?	◯	◯	
Been in an auto accident?	◯	◯	
Had sprains/strains?	◯	◯	
Been struck unconscious?	◯	◯	
Had surgery?	◯	◯	

Family History

Family Members - Present and past health conditions

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

☐ Other ____________________

Pain Level	No	Yes
Do you experience pain everyday?	◯	◯
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?	◯	◯

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

Have you ever suffered from...

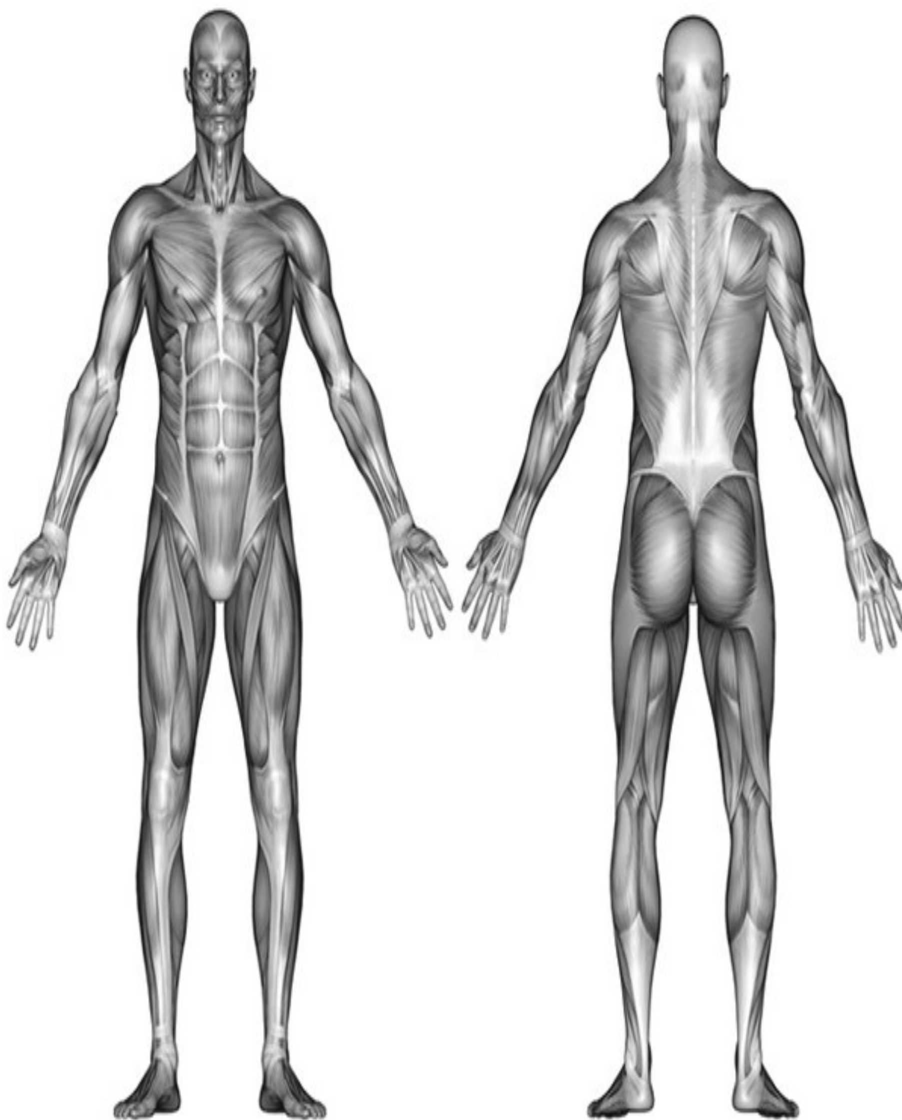
- [ ] Alcoholism
- [ ] Allergies
- [ ] Anemia
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Back Pain
- [ ] Breast Lump
- [ ] Bronchitis
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chest Pain/ Conditions
- [ ] Cold Extremities
- [ ] Constipation
- [ ] Cramps
- [ ] Depression
- [ ] Diabetes
- [ ] Digestion Problems
- [ ] Dizziness
- [ ] Ears Ring
- [ ] Excessive Menstruation
- [ ] Eye Pain or Difficulties
- [ ] Fatigue
- [ ] Frequent Urination
- [ ] Headache
- [ ] Hemorrhoids
- [ ] High Blood Pressure
- [ ] Hot Flashes
- [ ] Irregular Heart Beat
- [ ] Irregular 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
- [ ] Pacemaker
- [ ] 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: ____________________

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 & Needles

N = Numbness   **S** = Stabbing



Current complaint (how you feel today):