NEW PATIENT HEALTH HISTORY FORM **In order to provide you the best possible wellness care, please complete this form All information is strictly CONFIDENTIAL (please print)**	ACCOUNT # ______________ DATE: ___________________ AGE: ____________________

First Name ____________________________ Last Name __________________________ MI ____

Address __________________________________ City __________ State _____ Zip ___________

Telephone Cell ___________________ Home ____________________ Work _________________

Best # to contact: (circle) Cell Home Work Drivers License # ___________________________

Social Security # _________________________ Date of Birth ________________ Age ________

Email address: ____

Sex: Male Female Marital Status: (circle) Sin Mar Div Wid Children(s)/Ages _________

Occupation _____________________________ Employer __________________________________

Employer Address: ____

How long at present job? ________ How many hours do you normally work per week? ______

Have you ever been to a chiropractor before? _____ If yes, when/where? ______________________

For what reason? ____

Emergency Contact: ________________________________ Relationship ______________________

Phone Number ________________________ Address ______________________________________

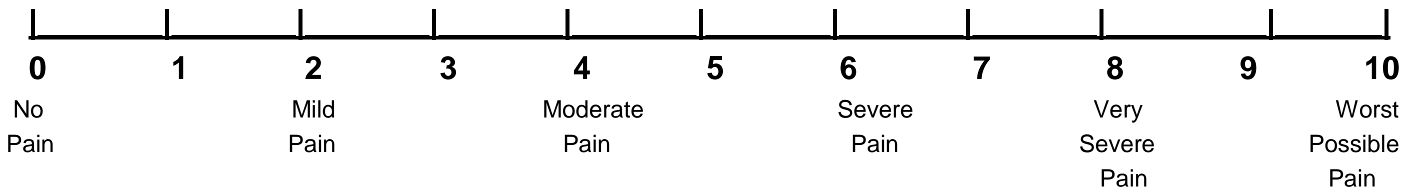
PLEASE LIST YOUR PRIMARY REASON(S) FOR TODAY'S VISIT:

1. _______________________________________ For how long? _________________________
2. _______________________________________ For how long? _________________________
3. _______________________________________ For how long? _________________________

How does the primary complaint feel ☐ dull/achy ☐ sharp ☐ numb ☐ tingling ☐ burning/cold

How often do you experience the primary complaint? ☐ constant ☐ daily ☐ wkly ☐ monthly

Using the scale below, rate how your **primary complaint affects your life**



Does your pain wake you at night? ☐ Yes ☐ No ☐ Occasionally

Are your symptoms worse during certain parts of the day? ☐ Yes ☐ No am pm all day (circle)

Do changes in weather affect your symptoms? ☐ Yes ☐ No

Do you wear orthotics? ☐ Yes ☐ No

What activities aggravate your symptoms? ____

What activities help to improve your symptoms? ____

How were you referred to this office? ☐ Friend ______________________________

☐ Internet ____________________ ☐ Physician ______________________________

☐ Phone Book _________________________ please be specific ☐ Other ____________________

Have you consulted with any other doctors for **THESE COMPLAINTS**? ☐ Yes ☐ No

1. ___________________________ Phone # / Address __________________________________
2. ___________________________ Phone # / Address __________________________________

Have you been treated for **<u>any other</u>** health conditions in the past 12 months? ☐ Yes ☐ No

If yes, please describe ____

Date of last physical exam: _______________ When were your last x-rays taken? _______________

Are you currently taking any medications? If yes, please list name/dosage _____________________

____

Have you ever had any of the following? If yes, please describe

Broken Bones? Yes No ____

Surgeries? Yes No ____

Hospitalized? Yes No ____

Auto Accident Yes No ____

Sprains/Strains? Yes No ____

Struck Unconscious? Yes No ____

Were you recently involved in an automobile accident or work related accident? ☐ Yes ☐ No

If yes: What was the date of the accident? ________________ Time: _________ a.m. / p.m.

Were you hospitalized? ☐ Yes ☐ No If yes, where? ________________________________

What treatment did you receive? ____

If this is related to an auto accident, what is the name of your insurance company?

_________________________________ Have you reported the accident? ☐ Yes ☐ No

Additional forms will be provided to you on check out today, these forms are <u>required to be returned</u> on your next visit.

WOMEN ONLY – X-rays are contra-indicated during pregnancy. This office does not knowingly x-ray women who are may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant please let the doctor or assistant know right now.

Are you pregnant? ☐ Yes ☐ No Date of Last Menstrual Period ______________________

Do you want to take a pregnancy test now? ☐ Yes ☐ No

Please mark the situations as they pertain to you.

Cramps ☐ Excessive flow ☐ Hot flashes ☐ Irregular cycle ☐

Painful periods ☐ Tubal ligation ☐ Complete/partial hysterectomy ☐

Take birth control pills ☐ please indicate type___________________________

Trying to get pregnant ☐

1. All first visit charges are payable when services are rendered. _________ *Initials*
2. The fee paid for treatment x-rays is for analysis only. The film(s) are the property of this office, if you desire copies additional fees apply. _________ *Initials*
3. What is your method of payment to take care of today's charges? ☐ Cash ☐ Check ☐ Credit

INSURANCE INFORMATION **Do you have any type of health insurance? ☐ Yes ☐ No**
Please provide your insurance card so we may make a copy for our records.

Insurance Company Name ____

Insured Name if not self __________________________________ Date of Birth ___________________

Relationship to insured ___________________________________

SIGNATURE

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services.
- It is my responsibility to complete the office forms accurately and to notify the doctor(s) if any of my information has changed or required updating.
- I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney fees, filing fees, collections fees, interest and legal fees including court fees if legal action becomes necessary to collect on this account. I authorized Wards Corner Chiropractic to obtain a credit report if necessary.
- I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I understand there is no guarantee that my health insurance plan or policy will pay for all or part of my care. Furthermore, I understand Wards Corner Chiropractic will prepare any necessary reports and/or forms to assist me in making collections from the insurance company. Any amount authorized is to be paid directly to Wards Corner Chiropractic and will be credited to my account on receipt.
- Furthermore I agree that should my insurance status change I will notify the office immediately
- I have completed this form to the best of my knowledge and agree to the above financial terms.
- *The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had the opportunity to receive a copy.* _________ *Initials*

____ ____________________

Signature of Patient / Responsible Party Date