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.

Today's Date _____

FULL NAME (FIRST, MIDDLE, LAST) _____

PERMANENT MAILING ADDRESS _____

IF DIFFERENT, BILLING ADDRESS_____

TELEPHONE NUMBER _____

TELEPHONE TYPE (CIRCLE ONE) CELL HOME WORK

EMAIL _____

DOB _____ MALE FEMALE

EMPLOYER: NAME AND PHONE_____

EMERGENCY CONTACT NAME AND PHONE _____

REFERRED BY (IF APPLICABLE) _____

MARITAL STATUS _____

SPOUSE'S NAME AND PHONE_____

PREVIOUS CHIROPRACTIC CARE

HAVE YOU SEEN A CHIROPRACTOR BEFORE (CIRCLE ONE) YES NO

APPROXIMATE DATES OF RECENT VISITS _____

NAME OF CHIROPRACTOR AND CITY WHERE LOCATED _____

COMPLETE THIS SECTION ONLY IF YOUR VISIT IS RELATED TO A CAR ACCIDENT

DATE OF ACCIDENT _____

DID YOU SEE A PHYSICIAN FOR THE ACCIDENT (CIRCLE ONE) YES NO

IF SO, PLEASE PROVIDE DOCTOR'S NAME AND FACILITY WHERE YOU WERE SEEN

_____

NAME AND CONTACT INFORMATION FOR YOUR CAR INSURER_____

_____

NAME AND CONTACT INFORMATION FOR YOUR ADJUSTER _____

_____

IF YOU HAVE BEEN IN A PREVIOUS CAR ACCIDENT(S) PLEASE STATE YOUR AGE(S) AT THE TIME OF EACH ACCIDENT AND DESCRIBE THE CIRCUMSTANCES OF EACH ACCIDENT

_____

COMPLETE THIS SECTION ONLY IF YOUR VISIT IS RELATED TO A WORK INJURY

DATE OF ACCIDENT _____

STATE WHERE ACCIDENT OCCURRED _____

DATE ACCIDENT WAS REPORTED TO EMPLOYER _____

DID YOU SEE A PHYSICIAN FOR THE ACCIDENT (CIRCLE ONE) YES NO

IF SO, PLEASE PROVIDE DOCTOR'S NAME AND FACILITY WHERE YOU WERE SEEN

_____

NAME AND CONTACT INFORMATION FOR YOUR ADJUSTER _____

_____

COMPLETE THIS SECTION FOR ALL OTHER VISITS THAT ARE NOT RELATED TO A CAR ACCIDENT OR A WORK INJURY

DATE SYMPTOMS BEGAN _____

WHAT CAUSED SYMPTOMS (IF KNOWN) _____

DESCRIBE SYMPTOMS _____

_____

MEDICAL HISTORY

CURRENT HEIGHT AND WEIGHT _____

IF YOUR PARENTS OR SIBLINGS HAVE ANY HISTORY OF HEART DISEASE, CANCER, DIABETES OR ARTHRITIS, PLEASE DESCRIBE

_____

_____

IF YOU CURRENTLY SEE A MEDICAL DOCTOR, PHYSICAL THERAPIST, PSYCHOLOGIST, PSYCHIATRIST, HERBALIST, NUTRITIONIST OR ANY OTHER MEDICAL OR ALTERNATIVE MEDICAL PRACTITIONER, PLEASE LIST THEIR NAME AND CONTACT INFORMATION, STATE THE CONDITION(S) FOR WHICH YOU ARE BEING TREATED, AND LIST ONGOING TREATMENTS BELOW

_____

_____

PLEASE LIST ALL MEDICATIONS WITH THE DOSES OF EACH (ALTERNATIVELY, PLEASE BRING A LIST OF CURRENT MEDICATIONS TO YOUR NEXT VISIT)

_____

_____

_____

IF YOU USE OR HAVE USED HERBAL REMEDIES, VITAMINS AND/OR "ALTERNATIVE MEDICINE OR TREATMENTS", PLEASE STATE WHEN USE OCCURRED, NAME OF PRODUCT(S) TAKEN, AND WHETHER USE CONTINUES OR DATE IT WAS DISCONTINUED

_____

PLEASE LIST ALL MEDICATION ALLERGIES (NOT SEASONAL ALLERGIES)

_____

IF YOU HAD X-RAYS TAKEN IN THE PAST TWO YEARS, PLEASE DESCRIBE CIRCUMSTANCES

_____

IF YOU HAVE HAD A BROKEN BONE(S) IN THE PAST TWO YEARS, PLEASE DESCRIBE CIRCUMSTANCES

_____

IF YOU HAVE BEEN STRUCK UNCONSCIOUS IN THE PAST TWO YEARS, PLEASE DESCRIBE CIRCUMSTANCES

_____

IF YOU HAVE HAD SPRAINS/STRAINS OF ANY TYPE IN THE PAST TWO YEARS, PLEASE DESCRIBE CIRCUMSTANCES

_____

IF YOU HAVE HAD SURGERY IN THE PAST TWO YEARS, PLEASE DESCRIBE CIRCUMSTANCES

_____

PLEASE SELECT TO INDICATE IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:

ANEMIA	YES	NO
ARTERIOSCLEROSIS	YES	NO
ARTHRITIS	YES	NO
ASTHMA	YES	NO
BREAST LUMP(S)	YES	NO
BRONCHITIS	YES	NO

BRUISE EASILY	YES	NO
CANCER	YES	NO
CHEST PAINS	YES	NO
COLD HANDS OR FEET	YES	NO
CONSTIPATION	YES	NO
DEPRESSION	YES	NO
DIABETES (TYPE I)	YES	NO
DIABETES (TYPE II)	YES	NO
DIGESTION PROBLEMS	YES	NO
DIZZINESS	YES	NO
RINGING IN EARS	YES	NO
MENSTRUAL DIFFICULTIES	YES	NO
EYE PAIN OR PROBLEMS	YES	NO
UNEXPLAINED FATIGUE	YES	NO
FREQUENT URINATION	YES	NO
FREQUENT HEADACHES	YES	NO
HEMORRHOIDS	YES	NO
HIGH BLOOD PRESSURE	YES	NO
IRREGULAR HEART BEAT	YES	NO
KIDNEY INFECTION	YES	NO
KIDNEY STONES	YES	NO
LOSS OF MEMORY	YES	NO
LOSS OF BALANCE	YES	NO
NECK PAIN/STIFFNESS	YES	NO
NOSE BLEEDS	YES	NO
PACEMAKER	YES	NO
POLIO	YES	NO
PROSTATE TROUBLE	YES	NO
SCIATICA	YES	NO
SCOLIOSIS	YES	NO
SHORTNESS OF BREATH	YES	NO
FREQUENT SINUS INFECTIONS	YES	NO
SLEEP PROBLEMS/INSOMNIA	YES	NO
STROKE	YES	NO
SWOLLEN ANKLES	YES	NO
SWOLLEN JOINTS	YES	NO
THYROID CONDITION	YES	NO
TUBERCULOSIS	YES	NO
ULCERS	YES	NO
VARICOSE VEINS	YES	NO
HIV/AIDS	YES	NO
HEPATITIS A	YES	NO
HEPATITIS B	YES	NO
HEPATITIS C	YES	NO

HABITS

CAFFEINE: TYPE OF PRODUCT AND AMOUNT USED PER DAY

_____

TOBACCO: TYPE OF PRODUCT AND AMOUNT USED PER DAY

_____

ALCOHOL: TYPE OF PRODUCT AND AMOUNT USED PER WEEK

_____

IF YOU USE, OR HAVE USED THE FOLLOWING "STREET DRUGS": MARIJURANA, HEROIN, COCAINE, METHAMPHETAMINE OR OXYCONTIN, OR ANY OTHER DRUG OR SUBSTANCE CURRENTLY KNOWN TO BE UNLAWFUL IN THIS STATE AND/OR THE UNITED STATES, PLEASE STATE DRUG USED, AMOUNT OF USE, AGE AT WHICH USE STARTED AND, IF APPLICABLE, ANY ATTEMPTS TO QUIT OR ANY DOCTOR OR THERAPIST YOU ARE SEEING OR HAVE SEEN FOR THIS ISSUE

_____

_____

IF YOU ARE OR EVER WERE INVOLVED IN A CLINICAL TRIAL FOR ANY MEDICINE OR PRODUCT, PLEASE STATE THE DATE(S) OF THE TRIAL, THE MEDICINE OR PRODUCT INVOLVED, AND THE DATE THE TRIAL ENDED

_____

_____

IF YOU HAVE BEEN OUT OF THE COUNTRY IN THE PAST 180 DAYS, PLEASE LIST ALL COUNTRIES TRAVELED TO AND ANY ILLNESS SUSTAINED WHILE OUT OF THE U.S. OR UPON RETURNING HOME

_____

_____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me, and the filing of such claims by Storlie Family Chiropractic is a courtesy to me. ***In order to process your claims in a timely manner, we <u>must</u> have your most up-to-date insurance on file*** I understand and agree that all services charged and/or rendered to me are my personal responsibility for timely payment (no later than 90 days after the date of service). I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered will become immediately due and payable.

NAME AND DOB OF PERSON RESPONSIBLE FOR PATIENT'S TREATMENT (IF NOT SELF)

_____

PATIENT'S SIGNATURE (OR IF PATIENT IS A MINOR, PARENT/GUARDIAN'S SIGNATURE)[1]

_____ DATE_____

[1] Note: If signer is Patient's legal guardian, please provide a certified copy of Letters of Guardianship not later than Patient's next appointment.