

New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name _____ Date _____

Email _____

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

Mailing address

Address _____ City _____ State _____ Zip _____

Telephone (work) _____ (home/cell) _____ Referred By _____

Age _____ Birth date _____ Social Security # _____ Number of children _____

Occupation _____

Marital Status _____ Spouse's name _____ Spouse's Occupation _____

Emergency contact _____ Phone _____

Current Complaints

Please describe:

Date of injury _____ Date symptoms appeared _____

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

List other practioners seen for this condition

Have you ever been under chiropractic care? No Yes

If yes, please describe

Agreement

I understand and agree that I am receiving wellness care at TLC For Life. I understand that wellness care will not be coded for insurance reimbursement nor is it a benefit payable by health insurance. I understand and agree that all services rendered to me and charged are my personal responsibility, payable at time of service. I understand that if I suspend or terminate my care/treatment plan, payment of the remainder is due upon termination.

Patient's 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 condition, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in an auto accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Sprains/Strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family History	
Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do your symptoms interfere with daily life?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does pain wake you up at night?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are your symptoms worse during certain times of the day?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do changes in weather affect your symptoms?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you wear orthotics?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you take vitamin supplements?	<input type="checkbox"/> No <input type="checkbox"/> Yes
What activities aggravate your symptoms?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Habits	None	Light	Moderate	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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/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/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

