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 general office announcements and promotions.

Mailing address

Address ______________________ City ________ State ______ Zip ______

Telephone (work) ________ (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 ______________

Current Complaints

Nature of injury: Automobile* ☐ Work ☐ Other ☐

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 injury/condition ______________

Have you ever been under chiropractic care? ☐ No ☐ Yes

If yes, please describe ____

Insurance Information

Name of party responsible for payment ______________ Phone ______________

Do you have health insurance? ☐ No ☐ Yes Name of company ______________

** If an auto accident please provide:*

Insurance company name ______________ Contact person ______________

Phone ______________________ Claim # ______________________

Billing Address

Name of the insured ____

I understand and agree that health/accident insurance policies are an arrangement between an 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.

Patient's signature ______________________________ Date ______________

Spouse's or guardian's signature ______________________ Date ______________