



NEW PATIENT HEALTH HISTORY

Please complete this form before your first visit and bring it with you. Do not email completed paperwork containing private health information.

PATIENT INFORMATION

Legal name		Preferred name	
Date of birth	Age	Pronouns	Today's date
Street address	City	State	ZIP
Mobile phone	Other phone	Email	
Occupation	Employer		
Emergency contact	Relationship	Phone	
Preferred contact: ☐ Call ☐ Text ☐ Email May we leave a voicemail? ☐ Yes ☐ No			

INSURANCE AND VISIT DETAILS

Insurance carrier	Member ID	Group number
Policyholder name	Policyholder date of birth	Relationship to patient
Visit type: ☐ General chiropractic ☐ Wellness ☐ Auto injury ☐ Work injury ☐ Other		
If injury-related, date of injury Attorney / claim contact (if applicable)		

PRIMARY CONCERN

What is the main reason for your visit?

When did it begin?	How did it begin?	Pain now (0-10)	Pain at worst (0-10)
Symptoms are: ☐ Improving ☐ Unchanged ☐ Worsening Frequency: ☐ Constant ☐ Frequent ☐ Occasional			
☐ Sharp	☐ Dull / aching	☐ Burning	
☐ Numbness	☐ Tingling	☐ Weakness	
☐ Stiffness	☐ Spasm	☐ Other	

What makes your symptoms better or worse?

What activities are limited?

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HEALTH HISTORY

Check any condition you have now or have had in the past. Add details in the space below.

- | | | |
|--|---|---|
| ☐ High blood pressure | ☐ Heart disease | ☐ Stroke / TIA |
| ☐ Diabetes | ☐ Cancer | ☐ Seizures |
| ☐ Osteoporosis | ☐ Arthritis | ☐ Autoimmune condition |
| ☐ Kidney disease | ☐ Liver disease | ☐ Thyroid condition |
| ☐ Asthma / lung disease | ☐ Blood clotting issue | ☐ Neuropathy |
| ☐ Migraine / headache | ☐ Depression / anxiety | ☐ Recent fever / infection |
| ☐ Unexplained weight change | ☐ Dizziness / fainting | ☐ Bowel / bladder change |
| ☐ Night pain | ☐ Pregnant / possibly pregnant | ☐ Other |

Please explain checked conditions, including approximate dates

Current medications and supplements (name, dose, reason)

Medication, food, latex, or environmental allergies and reactions

Surgeries, hospitalizations, fractures, or major injuries (include dates)

Primary care provider

Provider phone

Other specialists currently treating you

Last physical exam

Have you had imaging for this concern? ☐ No ☐ X-ray ☐ MRI ☐ CT ☐ Other

Imaging date / location

Results if known

LIFESTYLE

Tobacco: ☐ Never ☐ Former ☐ Current Alcohol: ☐ None ☐ Occasional ☐ Regular

Activity level: ☐ Low ☐ Moderate ☐ High Average sleep: _____ hours/night

Exercise, work duties, hobbies, and other activities relevant to your care

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PREVIOUS CARE AND GOALS

Have you received chiropractic care before? ☐ No ☐ Yes

Previous chiropractor / clinic

Approximate date of last visit

What helped, what did not help, and what questions do you have?

What are your top goals for care?

Select all that apply:

- | | | |
|---|---|---|
| ☐ Reduce pain | ☐ Move more comfortably | ☐ Return to work |
| ☐ Return to exercise / sport | ☐ Improve posture | ☐ Sleep better |
| ☐ Prevent recurrence | ☐ Improve daily function | ☐ Understand the cause |

SAFETY SCREENING

Please tell the clinical team immediately if you currently have any of the following:

- | | |
|---|--|
| ☐ New loss of bowel or bladder control | ☐ Numbness in the groin / saddle area |
| ☐ Sudden severe headache | ☐ Chest pain or trouble breathing |
| ☐ New facial droop, speech difficulty, or one-sided weakness | ☐ Recent major trauma |

If any of these symptoms are severe or sudden, seek emergency medical care rather than waiting for an office visit.

PATIENT ACKNOWLEDGMENT

I certify that the information I provided on this health history is complete and accurate to the best of my knowledge. I will tell the clinical team about changes in my health, medications, pregnancy status, or symptoms. This health-history form is not a consent to treatment; the office will review any required consent, privacy, and financial forms separately.

Patient / guardian signature

Printed name

Date

If guardian, relationship to patient

FOR OFFICE USE

Reviewed by: _____ Date: _____ Notes: _____