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 3rd parties and is used for general office announcements

Mailing Address

Address_____ City_____ State_____ Zip_____

Cell_____ Work_____ Home_____ Referred By_____

Age_____ Birth date _____ Social Security #_____ # 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 current complaints_____

_____

Severity of pain on your *WORST* day: LEAST WORST

1 2 3 4 5 6 7 8 9 10

Date of Injury_____ Date Symptoms appeared_____

Have you ever had same condition? Yes_____ No_____ If yes, when? _____

List other practitioners seen for this injury/condition_____

Have you ever been under chiropractic care? Yes_____ No_____ If yes, please describe_____

_____

Insurance Information

Name of party responsible for payment_____ Phone_____

Company Name_____ Do you have health insurance? Yes_____ No____

*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 me. 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_____

Chiropractic Physicians
Dr. Michael Staub D.C., F.I.A.M.A. and Dr. Shaun Hudson D.C.
The Bone and Joint Wellness Center
7701 E. Indian School Rd. Suite H
Scottsdale, AZ 85251
P: (480) 990-2663 ● F: (480) 941-2825

Medical History

Have you been treated for any conditions in the last year? Yes_____ No_____

If yes, Please describe_____

Date of last physical exam_____ Is there a chance that you are pregnant? Yes_____ No_____

Have you had x-rays taken? Yes_____ No_____ 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:	Yes	No	Briefly explain
Broken bones?	☐	☐	_____
Been hospitalized?	☐	☐	_____
Been in an auto accident?	☐	☐	_____
Had sprains/strains?	☐	☐	_____
Been struck unconscious?	☐	☐	_____
Had surgery?	☐	☐	_____

Family History

Family Member	Present and past health conditions (Ex. Heart disease, cancer, diabetes, arthritis, etc.)

Habits:	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

	Yes	No
Do you experience pain every day?	☐	☐
Do your symptoms interfere with daily life?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse during certain times of the day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐
Do you take vitamin supplements?	☐	☐

What activities aggravate your condition?

_____

_____

_____

_____

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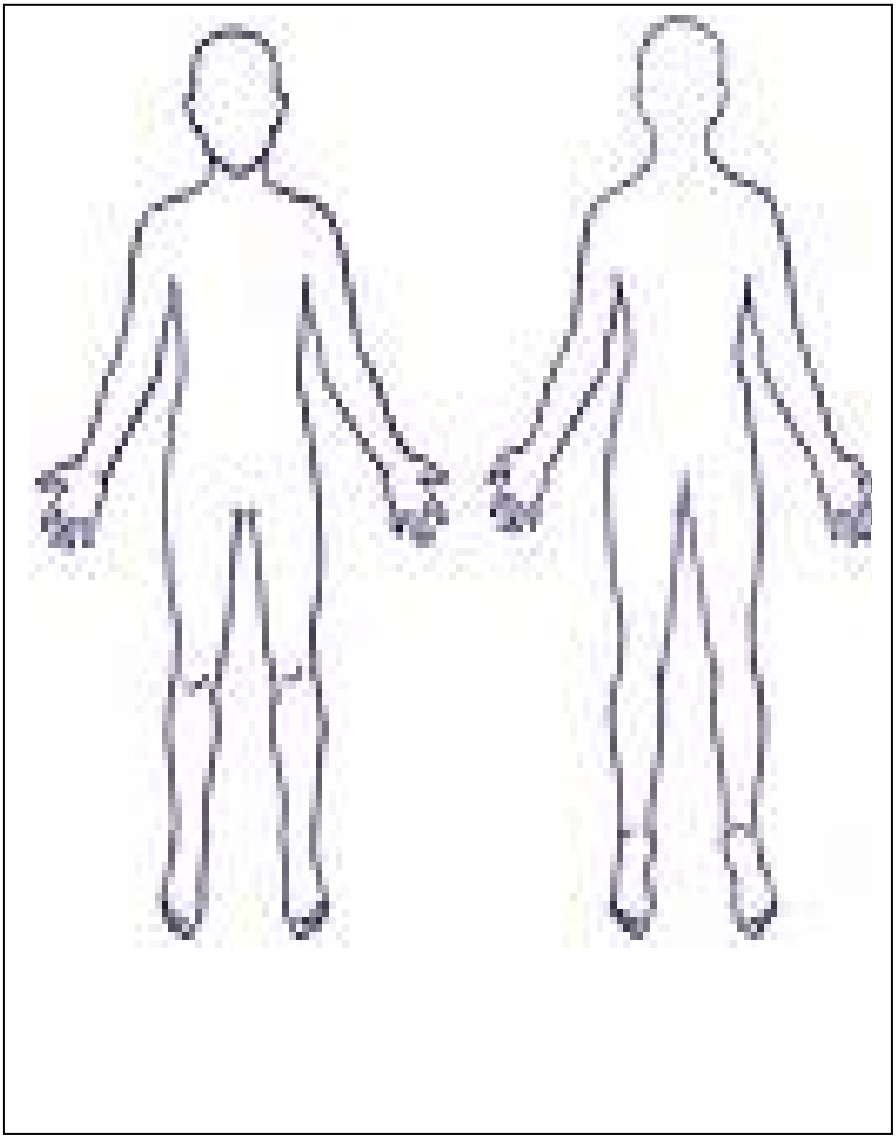
Have you suffered from any of the following in the past 6 months:

- Alcoholism ☐
- Allergies ☐
- Anemia ☐
- Arteriosclerosis ☐
- Arthritis ☐
- Asthma/Bronchitis ☐
- Back Pain ☐
- Breast Lump ☐
- Cancer ☐
- Chest Pain/Conditions ☐
- Cold Extremities ☐
- Diabetes ☐
- Dizziness ☐
- Ears Ring ☐
- Excessive Menstruation ☐
- Eye Pain/Difficulties ☐
- Fatigue ☐
- Frequent Urination ☐
- Headache ☐
- High Blood Pressure ☐
- Hot Flashes ☐
- Kidney Infection ☐
- Kidney Stones ☐
- Loss of Balance ☐
- Neck Pain/Stiffness ☐
- Pacemaker ☐
- Prostate Trouble ☐
- Sciatica ☐
- Shortness of Breath ☐
- Sleep problems/Insomnia ☐
- Spinal Curvatures ☐
- Stroke ☐
- Swelling of Ankles ☐
- Swollen Joints ☐
- Thyroid Condition ☐

Current Complaints (Continued)

Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

A=Ache	O=Other
B=Burning	P=Pins & Needles
N=Numbness	S=Stabbing



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