

NEW PATIENT HEALTH HISTORY FORM

WELCOME

Thank you for choosing **ACT Wellness Center**. As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you and your family the opportunity of improved health potential and wellness services in the future. We will be working together to help you and your family reach your health and wellness goals. We will conduct a thorough history and physical examination to decide if we can assist you. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better access the challenges to your health potential. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

If you ever have any questions about your chiropractic care, please don't hesitate to ask one of our highly educated chiropractic team members. All of your questions, even the ones you haven't even thought of yet, will be answered during your Chiropractic Report.

When completing this form if you require assistance or need an interpreter, please initial here _____.

Patient Data

Today's Date: _____
 Name _____ Social Security # _____
 Address _____ Drivers License # _____
 City _____ State _____ Zip _____
 Phone: (H) _____ (Cell) _____ Marital Status: Single Married Divorced Separated
 E-mail _____ Spouse's Name _____
 Date of Birth _____ (Age _____) Spouse's Social Security Number: _____
 Sex: Male Female Spouse's Occupation _____
 Name or Nickname I prefer to be called _____ Spouse's Business Phone: _____
 Your Occupation _____
 Work Address _____ Student at _____
 Work Phone _____ Full-Time Part-Time

Other Addresses Where You Reside (e.g., parents' home, any other address where you regularly reside)

Street _____
 City _____ State _____ Zip _____ Phone _____

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ___/___/___ Phone: _____
 Mother: _____ Date of Birth: ___/___/___ Phone: _____
 Guardian: _____ Date of Birth: ___/___/___ Phone: _____

Who do you normally live with? Mother & Father Father Mother Legal Guardian None of these

Contact in case of emergency, Name: _____ Telephone # _____

Is any other friend or member of your family being treated in this office? _____

Who may we thank for referring you to our office? _____

Family physician's name _____

Please send a report to my family physician. Yes No

Is your condition or injury due to an accident or work-related cause? YES NO Please check ALL that apply.

Did the condition or injury result from *automobile* accident? YES NO

Did it result from a *work-related* accident or cause? YES NO (briefly describe):

 If the condition did not result from an automobile accident or relate to your work, where did the accident occur?

 Approximately, when did your injury or condition occur? ___/___/___

Insurance Information

Who is responsible for your bill? You and: Spouse Workers' Compensation Car Insurance Medicare
 Blue Cross/Blue Shield Other _____

Health Insurance (Name): _____ Health Card # _____

Insured Person's Name: _____ Insured Person's Date of Birth: _____

Does the policy holder have the insurance through his/her employer? YES NO

If yes, who is the employer? _____

Your Health Profile

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Your Childhood Years

| | YES | NO | UNSURE | | YES | NO | UNSURE |
|--|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| ●Did you have any childhood illnesses? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ●Was there any prolonged use of medicine such as antibiotics or an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ●Did you have any serious falls? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ●Did you suffer from other traumas (physical or emotional)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ●Did you play youth sports? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ●Were you vaccinated? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ●Did you take / use any drugs? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ●As a child were you under regular chiropractic care? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ●Did you have any surgery? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| ●Have you fallen / jumped from a height over 3 feet? (i.e. cribs, beds, trees) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| ●Were you involved in any car accidents As a child? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |

Your Comments: _____

Adult Years (18 to present)

| | YES | NO | | YES | NO |
|----------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| ●Do / did you smoke? | <input type="checkbox"/> | <input type="checkbox"/> | ●Do / did you play adult sports? | <input type="checkbox"/> | <input type="checkbox"/> |
| ●Do / did you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | ●Do / did participate in extreme sports? | <input type="checkbox"/> | <input type="checkbox"/> |
| ●Have you been in any accidents? | <input type="checkbox"/> | <input type="checkbox"/> | ●Have you had any surgery? | <input type="checkbox"/> | <input type="checkbox"/> |

On a scale of 1 – 10 describe your stress level (1 = none / 10 = extreme): Occupational _____ Personal _____

On a scale of Poor, Good, Excellent describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

Are you presently taking any vitamins, herbs, or over the counter products (aspirin included)? Yes No

If yes, name them _____

Are you allergic to anything you are aware of? _____

Have you ever had any cosmetic surgery, pacemaker, rods, clips, breast implants, etc.? _____ Year _____

Do you have any reason to believe that you may be pregnant? Yes No Uncertain

Date of last menstrual period _____

Your Comments: _____

In the past 14 days have you experiences any of the following symptoms?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Rapid eye movement |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Buzzing in Ear |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Slurred speech |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Vertigo (dizziness) |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Depression | <input type="checkbox"/> Lost sight in one eye | <input type="checkbox"/> nausea |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Constipation | <input type="checkbox"/> Take birth control pills |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Drooping eyelid | <input type="checkbox"/> Difficulty in arranging words properly |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Double vision recently |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fever | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Ringing in your ears |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Fainting | <input type="checkbox"/> visual disturbances | <input type="checkbox"/> Nagging cough |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Pass out easily | |
| <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Loss of Balance | |
| <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Night sweats | |
- Have a headache or head pain that is unlike any you have had before.
Do you have any health problems not listed above? _____

Family History

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

- Children _____
- Spouse _____
- Mother _____
- Father _____
- Brothers / Sisters _____
- Others _____

Did you mother or father have any of the following: Put an **M** for mother, **F** for father and **B** for both.

- | | | |
|---|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcer or Stomach Problems | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizure-Convulsions | <input type="checkbox"/> Arthritis-Rheumatism |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Stroke (Please indicate age when stroke occurred, Mother _____ Father _____) | | |

Comments: _____

Current Complaints or Reason for Your Visit Today — Please be as specific as you can.

If you have no symptoms or complaints, and are here for wellness services, please initial here _____ “Wish to have Chiropractic Wellness Services” and skip to “Upon Completion of My First Visit”. Others need to describe the chief area of complaint and the effect it has had on your life.

- Major complaints and symptoms _____
Pain or Problem started on _____
Pains are: Sharp Dull Constant (more than 75% present) Intermittent (less than 25% present)
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is condition worse during certain times of the day? _____
Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
Have you ever had this condition before or a similar condition? _____
When? _____
Is this condition getting progressively worse? _____
What positions or activities aggravate your condition? _____

Upon Completion of Your First Visit...

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorneys who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

As a result of my chiropractic care, I would like to... (Check all that apply) Feel better quickly
 Have a healthier spine Live a healthier lifestyle Have a healthier body by keeping my nerve system healthy

If you wish to have a third person or chaperone present during your examination & treatment initial here: _____.

Signature

Date

Consent to Treat a Minor / Guardian Signature

Date

Chiropractic Assistant's Observations: _____