Initial Adult 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 occasional office announcements and promotions.

Mailing address

Address _______________________________________ City ______________ State _______________ Zip ________

Telephone (cell) ___________ (home) _____________(work)____________ 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 _____________________

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 ___________________

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 ____

Rate the severity of pain on a scale from 1(least pain) to 10(worst pain)___________________________

Is the pain constant? ❑ No ❑ Yes

Do you experience pain every day? ❑ No ❑ Yes

Do your symptoms interfere with daily life? ❑ No ❑ Yes

Does pain wake you up at night/disturb sleep? ❑ No ❑ Yes

Are your symptoms worse during certain times of the day? ❑ No ❑ Yes

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Do changes in weather affect your symptoms? ❑ No ❑ Yes
Is the pain/symptom getting progressively worse? ❑ No ❑ Yes
Do you wear orthotics? ❑ No ❑ Yes
What activities aggravate your symptoms? ______________________________
Describe the pain (ie: sharp, achy, tingling): ______________________________

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?	❑	❑	______________
Been hospitalized?	❑	❑	______________
Been in an auto accident?	❑	❑	______________
Had Sprains/Strains?	❑	❑	______________
Been struck unconscious?	❑	❑	______________
Had surgery?	❑	❑	______________

Family History

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

Habits			None	Light	Moderate	Heavy
Alcohol	Drinks/Week_______		❑	❑	❑	❑
Coffee	Drinks/Week_______		❑	❑	❑	❑
Tobacco	Packs/Day________		❑	❑	❑	❑
Drugs	Recreational______	Prescription______	❑	❑	❑	❑
Exercise	Days/Week_______		❑	❑	❑	❑
Sleep	Hours/Night_______		❑	❑	❑	❑
Soft Drinks	Drinks/Week______		❑	❑	❑	❑
Water	Cups or Oz/Day_____		❑	❑	❑	❑
Appetite			❑	❑	❑	❑
Salty Foods			❑	❑	❑	❑
Sugary Foods			❑	❑	❑	❑
Artificial Sweeteners			❑	❑	❑	❑
Stress Level			❑	❑	❑	❑

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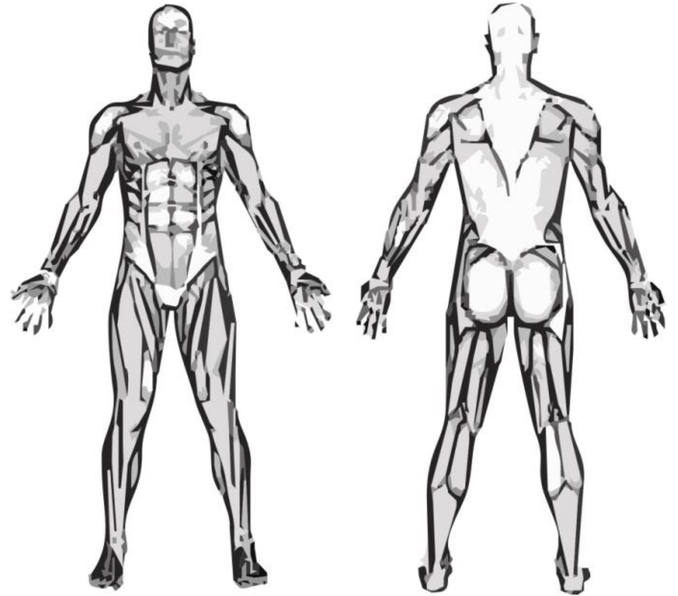
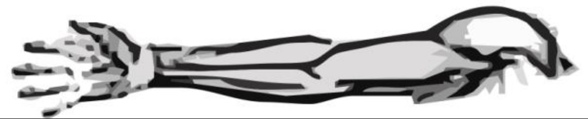
Have you ever suffered from:	
❑ AIDS/HIV	❑ High Cholesterol
❑ Alcoholism	❑ Hot Flashes
❑ Allergies	❑ Irregular Cycle
❑ Anemia	❑ Irregular Heart Beat
❑ Arteriosclerosis	❑ Kidney Infection/Disease
❑ Arthritis	❑ Kidney Stones
❑ Asthma	❑ Liver Disease
❑ Back Pain	❑ Loss of balance
❑ Breast lump(s)	❑ Loss of memory
❑ Bronchitis	❑ Loss of smell
❑ Bruise Easily	❑ Loss of taste
❑ Cancer	❑ Neck Pain or Stiffness
❑ Chemical dependency	❑ Nervousness
❑ Chest Pain/Conditions	❑ Nosebleeds
❑ Chicken Pox	❑ Pacemaker
❑ Cold extremities	❑ Parkinson's Disease
❑ Constipation	❑ Polio
❑ Cramps	❑ Poor Posture
❑ Depression	❑ Prostate Trouble
❑ Diabetes	❑ Prosthesis
❑ Digestion Problems	❑ Scarlet Fever
❑ Dizziness	❑ Sciatica
❑ Ears Ring	❑ Seizures/Epilepsy
❑ Eating Disorders	❑ Shortness of breath
❑ Emphysema	❑ Sinus Infection
❑ Excessive Menstruation	❑ Sleep problems/insomnia
❑ Eye Pain/Difficulties	❑ Spinal Curvatures
❑ Fatigue	❑ Stroke
❑ Frequent Urination	❑ Swelling of ankles
❑ Gout	❑ Swollen Joints
❑ Headache	❑ Thyroid Condition
❑ Hemorrhoids	❑ Tuberculosis
❑ Hepatitis	❑ Ulcers
❑ Herniated disc	❑ Vaginal Infections
❑ High Blood Pressure	❑ 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





I certify that all information provided has been answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physio-therapy, diagnostic tests and x-ray procedures, on myself (or the patient below, for whom I am legally responsible) by Dr. Lisa Wood and staff. It is understandable that as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including but not limited to fractures, disc injury, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure that the doctor feels at the time, based upon all factors then known, is in my best interest. I understand that results are not guaranteed. I have read or have had read to me the above consent. If I had any questions regarding its content, I did not sign below until I had them sufficiently answered. By signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I request treatment.

____________________ Printed Patient Name

____________________ Patient or Guardian Signature

__________ Date

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