



NEW PATIENT HEALTH HISTORY

The information supplied in this form is strictly confidential and considered protected health information as defined by HIPAA. Please refer to Connections Chiropractic's HIPAA Privacy Statement for further information.

Patient Information

Name: _____ Date: _____
Full Address: _____
Phone Numbers: (H) _____ (W) _____
(C) _____ E-mail: _____
Birth Date: _____ Age: _____ Social Security #: _____
Marital Status: M S W D Number of Children: _____
Spouse's Name: _____ Spouse's DOB: _____
Your Occupation: _____ Employer: _____
How did you hear about Connections Chiropractic: _____
Emergency Contact: _____ Phone: _____

Current Condition/Injury

Is the condition due to injury or illness arising out of employment? _____

Is the condition due to injury or illness arising out of an auto or other type of accident? _____

Date symptoms appeared/date of accident: _____ Number of lost work days: _____

Briefly describe the reason for your visit here: _____

Have you ever had the same or a similar condition in the past? Yes No If yes, please describe: _____

Please list all doctors you have seen related to your current concern including any chiropractors or family medical practitioners. If possible, please list the approximate date of your last visit and the doctors' telephone numbers.

1. _____
2. _____
3. _____

Please describe any special tests performed to investigate your current condition (i.e., X-ray, MRI, EKG, blood work):

Please list any medications taken in the past year (including vitamins & other supplements) with the dose and frequency taken:

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |



I, the undersigned, understand that I am financially responsible for all charges whether or not covered by insurance. I consent to proceed with the interview and examination. I understand that any treatment offered will be explained to me and my verbal consent will be requested before any care is rendered.

Patient Signature: _____ Date: _____



1. List the major problems you are experiencing? _____

2. If this is a reoccurrence, when did you previously have this problem? _____

What initially caused the problem? _____

3. Has it changed recently? Better Worse Same What types of treatment have you tried? _____

What makes it better? _____ Worse? _____

4. How frequent is the condition? _____ How long does it last? _____

5. Has your sleep been affected? Yes No If yes, please describe: _____

6. Is your ability to perform your job or daily activities affected? Yes No If yes, please describe: _____

7. Are there any other symptoms that may be related to these concerns which you have not listed? Yes No

If yes, please describe: _____

Severity & Location of Symptoms

Please mark an "X" on the line below to indicate the severity of your condition:

No symptoms
Does not interfere with activities

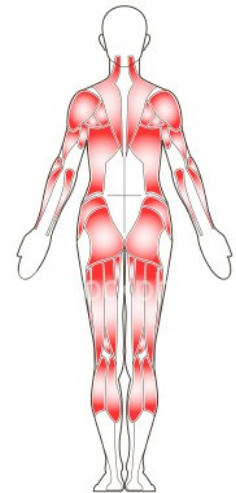
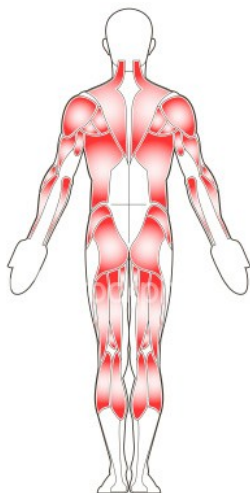
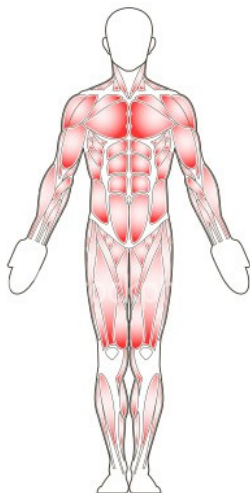
Extreme symptoms
Disabling



Please mark any areas of concern on the diagrams below — N = numbness, P = pins & needles, B = burning, A = aching, S = stabbing — Indicate any other problems as best you can.

MALE

FEMALE



FRONT VIEW

BACK VIEW

FRONT VIEW

BACK VIEW



Please check all that apply & indicate whether this is a current or old concern by providing an approximate date it last occurred.

GENERAL

- Fever
- Night sweats
- Nervousness
- Bleeding
- Diabetes
- Thyroid issues
- Headache
- Fainting
- Depression
- Memory loss
- Chills
- Fatigue
- Weight loss/gain
- Anemia
- Cancer
- Substance abuse
- Dizziness
- Seizures
- Phobias
- Waking in the night
- Problems falling asleep
- Surgeries/hospitalizations (describe): _____

- Broken bones, care accidents, or other injuries (describe): _____

GASTROINTESTINAL

- Belching/gas
- Vomiting
- Bloody stool
- Hernia
- Constipation
- Diarrhea
- Abdominal Pain
- Nausea
- Liver problems
- Other: _____

RESPIRATORY

- Problems breathing
- Spitting phlegm/blood
- Allergies
- Asthma
- Shortness of breath
- Chronic cough
- Pneumonia/bronchitis
- Other: _____

CARDIOVASCULAR

- Irregular heartbeat
- Racing heart
- Chest pain
- High blood pressure
- Swelling
- Prior health problem
- Pacemaker
- Stroke
- Other _____

MUSCULOSKELETAL

- Stiffness
- Pain
- Swelling
- Arthritis
- Weakness
- Twitching
- Tremors
- Numbness
- Other _____

SKIN

- Rashes
- Mole changes
- Itching
- Nail changes
- redness
- Other _____

EENT

- Blurry vision
- Double vision
- Eye pain
- Jaw pain
- Hearing loss
- Ringing in ears
- Ear infection
- Sinus problems
- Nosebleeds
- Throat problems
- Speech problems
- Glasses/Contacts? _____

GENITOURINARY

- Frequent/painful urination
- Incontinence
- Blood in urine or stool
- Urinary infection
- Venereal infection
- Other _____

TO BE COMPLETED BY WOMEN

- Difficult periods
- Hot flashes
- Irregular cycles
- Breast pain
- Lump in breast
- Difficulty becoming pregnant
- Complications of pregnancy
- Other _____

Date last period ended _____

Date of last GYN exam _____

TO BE COMPLETED BY MEN

- Testicular pain
- Prostate problems
- Difficult erection
- Low sperm count

EXERCISE ROUTINE

- None
 - 1-2 times per week
 - 3-4 times per week
 - 5-7 times per week
- What type? _____

PERSONAL HABITS

- Smoke _____ packs/day _____ years
- Alcohol _____ drinks/week
- Caffeine _____ cups/day
- Recreational drug use _____
- Use of artificial sweetener

FAMILY HISTORY

Are your parents living? _____
If so, do you consider them to be in good health? _____

Ages: Mother _____ Father _____

Check any items below that apply to your parents, siblings, or children:

- Diabetes
- Stroke
- Hypertension
- Cancer
- Seizures
- Tremors
- Brain disorder
- Heart disease
- Lung disease
- Arthritis
- Scoliosis

Any additional issues that may be of interest to the Doctor? _____