Standridge Clinic
Well Beyond Chiropractic

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

First Name_____ Last Name_____
Date_____ Email*_____

** Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.*

Mailing Address

Address_____
City_____ State_____ Zip_____
Phone *Work* (_____)_____ *Home* (_____)_____
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 (_____)_____

Current Complaints

Nature of Injury:_____
Please Describe:_____

_____

Date of Injury____/____/_____ Date Symptoms Appeared____/____/_____
Have you ever had same condition? ☐ Yes ☐ No If Yes, When?_____
List of other practitioners seen for this injury/condition_____

_____

Have you ever been under chiropractic care?_____
If Yes, Please Describe_____

_____

Insurance Information

Name of Party Responsible for Payment_____
Phone (_____)_____ Do you have health insurance? ☐ Yes ☐ No
Name of Company_____

** **If an auto accident, please provide:***
Insurance Company Name:_____
Contact Person_____Phone (_____)_____
Claim #_____

Signatures

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the Chiropractor or Chiropractic group insurance benefits otherwise payable to me. I understand that my Chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Name of the Insured_____

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Patient's Signature_____ Date___/___/____
Spouse's or Guardian's Signature_____ Date___/___/____

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 conditions, dosage, and frequency.)*

Have you ever:

Broken bones? ☐ Yes ☐ No Please Briefly Explain_____
Been hospitalized? ☐ Yes ☐ No Please Briefly Explain_____
Been in an auto accident? ☐ Yes ☐ No Please Briefly Explain_____
Had Sprains/Strains? ☐ Yes ☐ No Please Briefly Explain_____
Been struck unconscious? ☐ Yes ☐ No Please Briefly Explain_____
Had surgery? ☐ Yes ☐ No Please Briefly Explain_____

Family History

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

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

Habits

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

Have you ever suffered from:

☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Arteriosclerosis
☐ Arthritis
☐ Asthma
☐ Back Pain
☐ Breast Lump
☐ Bronchitis
☐ Bruise Easily
☐ Cancer
☐ Chest Pain/Conditions
☐ Cold Extremities
☐ Constipation
☐ Cramps
☐ Depression
☐ Diabetes
☐ Digestion Problems
☐ Dizziness
☐ Ears Ring
☐ Excessive Menstruation
☐ Eye Pain or Difficulties
☐ Fatigue
☐ Frequent Urination
☐ Headache
☐ Hemorrhoids
☐ High Blood Pressure
☐ Hot Flashes
☐ Irregular Heart Beat
☐ Irregular Cycle
☐ Kidney Infection
☐ Kidney Stones
☐ Loss of memory
☐ Loss of balance
☐ Loss of smell
☐ Loss of taste
☐ Lumps In Breast
☐ Neck Pain or Stiffness
☐ Nervousness
☐ Nosebleeds
☐ Pacemaker
☐ Polio
☐ Poor Posture
☐ Prostate Trouble
☐ Sciatica
☐ Shortness of breath
☐ Sinus Infection
☐ Sleep problems or Insomnia
☐ Spinal Curvatures
☐ Stroke
☐ Swelling of ankles
☐ Swollen Joints
☐ Thyroid Condition
☐ Tuberculosis
☐ Ulcers
☐ Varicose Veins

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