Health History

Name: ____________________ Address: ____________________

City: ______________ State: ____ Zip: ________ Home: ( ) _________ Cell: ( ) ________

Email: ____________________ SSN: ______________ Date of Birth: ___/___/___ Age: _____

Height: ________ Weight: _________ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced No. of children: _______

Name of Spouse (or parent): ______________ How were you referred to our office? ______________

(*Females only*) Are you pregnant? ☐ Yes ☐ No ☐ Unsure

Employer: ____________________ Address: ____________________

City: ______________ State: ____ Zip: ________

Work: ( ) _____________ Occupation: ____________________

Have you ever had Chiropractic care before? Yes / No If yes, when? ____________________

If you are experiencing any health problems, please list your chief complaints in order of severity

1. ____________________ How long? ______________
2. ____________________ How long? ______________
3. ____________________ How long? ______________

List other doctors consulted for these conditions:

1. ____________________ 2. ____________________

Family Physician's Name: ____________________ Phone: ( ) ___________

Address: ____________________

Do you ever experience any of these complaints while working? __________

If yes, describe the activities that may be causing you to experience these complaints:____________________

____

Are there other activities, incidents, or events outside of work that may have caused these complaints? ______

If Yes, explain: ____________________

____

If this is due to an injury or accident, what is the date of injury? ____________________

Have you ever had any surgeries or hospitalizations? _______ If yes, please list: ______________

____

Indicate medications (over the counter/prescriptions) you are currently taking: ☐ Aspirin/Tylenol

☐ Pain killers ☐ Muscle Relaxants ☐ Insulin ☐ Tranquilizers ☐ Birth Control Pills ☐ Others:

____

Have you been involved in an auto accident in the last 12 months? _______ If yes, when? ______________

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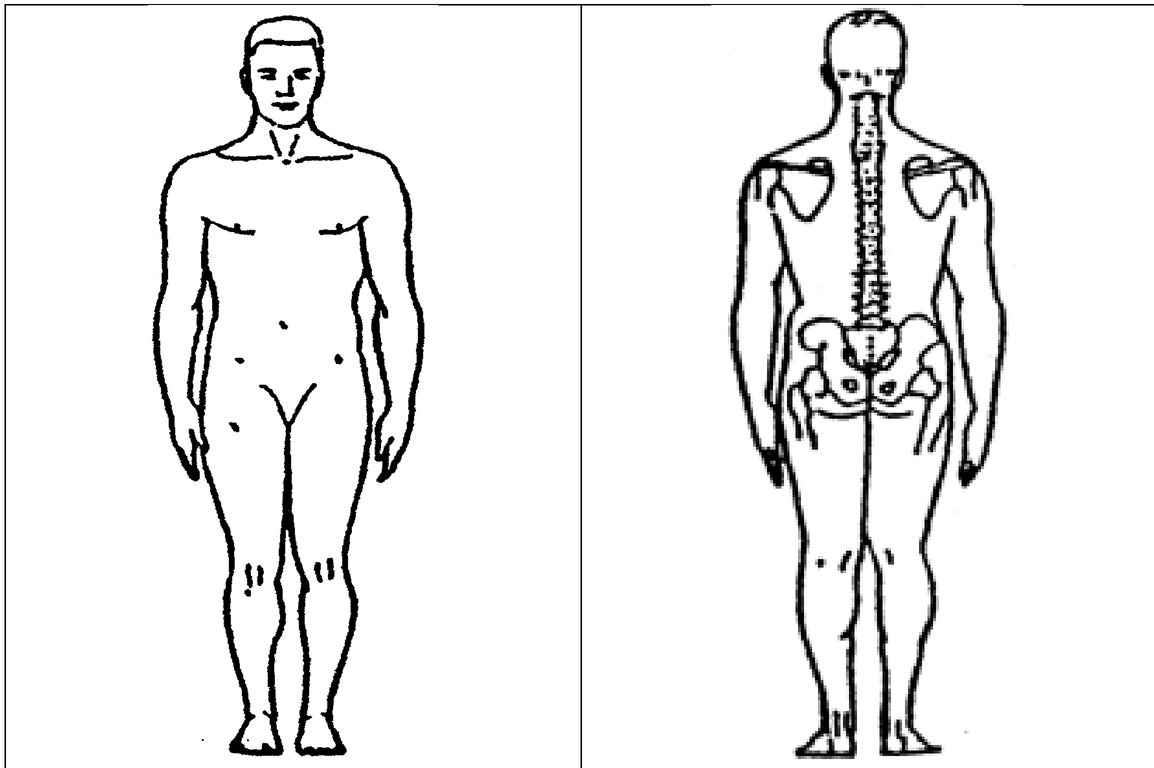
Health History

For your convenience, a complimentary insurance verification may be provided.

Simply provide us with a copy of your insurance card, and we'll verify your benefits.

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below.

COMPLETE THESE DIAGRAMS



NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE.

IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. California State Law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.

Patient's Signature ____ Date __________________________

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