QUALITY CARE CHIROPRACTIC LLC

New Patient Health History Form

Patient Information

Date _____

SS# _____

Name _____

Address _____

City _____

State _____ Zip _____

Email _____

Sex (circle one) M F

Birthdate _____

Occupation _____

Employer _____

Employer Address _____

Insurance Information

Insurance Co: _____

Policy#/ID#: _____

Group#: _____

Subscriber's Name: _____

Subscriber's Employer: _____

Relationship to Insured: _____

Secondary Insurance

Insurance Co: _____

Policy#/ID#: _____

Group#: _____

Phone Numbers

Home Phone (____) _____Cell Phone (____) _____

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone (____) _____ Work Phone _____

History

Chief complaint? (reason for visit)

_____

Secondary complaint? _____

Where are the symptoms located? _____

When did the symptoms begin? _____

What day exactly did the symptoms begin? _____

What caused the symptoms? (Trauma, Insidious) _____

Have the symptoms changed with time? _____

Have there been any new symptoms associated with it? _____

How has it progressed? _____

How long has it been since you felt well? _____

What makes the condition worse? (circle all that apply) lifting, bending, sitting, standing, twisting, working, any others? _____

What makes the condition better? (circle all that apply) Anti-inflammatory drugs, rest, ice, heat, adjustments, any others? _____

Describe the quality of pain? (circle all that apply) sharp pain on motion, constant, burning and/or hot feeling, sharp pain not on motion, stabbing or lightning like pain, tingling and/or numbness, cramping/knot and/or spasm, dull ache, radiating, deep burning, crawling sensation, throbbing pain, well localized, diffuse

Rate the severity of pain at rest and with activity on a scale of 0-10. 0 being no pain and 10 being the most excruciating pain. At rest _____ and with activity _____.

What is the intensity of pain? (circle one) minimal, slight, moderate, marked

Does the pain intensify at night? (circle one) YES/No

How much time during the day do you experience the pain normally? (circle one) less than an hour, between one and four hours, between four and eight hours, almost anytime of my awake hours, almost 24 hours a day.

What is the frequency of pain? (circle one) intermittent, occasional, frequent, constant

Health History Questionnaire

Have you seen any other healthcare provider for your complaint? YES NO

Name of doctors who have treated you for this condition (if applies) _____

Circle all of the diagnosis/treatments that apply:

Aids	Chicken Pox	Liver Disease	Rheumatoid Arthritis
Allergies	Diabetes	Measles	Rheumatic Fever
Anemia	Emphysema	Migraines	Stroke
Appendicitis	Epilepsy	Miscarriage	Thyroid Problems
Arthritis	Glaucoma	Multiple Sclerosis	Tonsillitis
Asthma	Goiter	Osteoporosis	Tuberculosis
Blood Disorders	Gonorrhea	Pacemaker	Fractures
Bronchitis	Gout	Pneumonia	Hypertension
Bulimia	Heart Disease	Polio	
Cancer	Hernia	Prostate Problems	
Cataracts	High Cholesterol	Kidney Disease	

Exercise	Work Activity	Habits (circle all that apply)	
None	Sitting	Smoking	Packs/Day_____
Moderate	Standing	Alcohol	Drinks/Week____
Daily	Light Labor	Caffeine	Cups/Day_____
Heavy	Heavy Labor	Stress	Reason_____

Are You Pregnant? YES NO If Yes, Due Date _____

List any Surgeries, Broken Bones, Traumas, Illnesses that you have had in the past

_____

Medications	Allergies	Vitamins/Supplements
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalizations

_____

_____

_____

As a new patient to Quality Care Chiropractic, it is of utmost importance that all health-related information is divulged to the physician to obtain and treat the patient to the best of the doctor's ability. All information is confidential and private and will be established between patient and doctor relationship which is to be compliant with HIPPA privacy regulations.

The service rendered by the treating physician will be paid for immediately following treatment. This is a cash and insurance based practice and a set fee will be discussed prior to treatment by the attending physician.

Please sign and date:

Patients Name _____ Date _____