GRAHAM CHIROPRACTIC CARE

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NEW PATIENT HISTORY FORM

To our new patients: In order to provide you with better care, please fill out all the questions as much as possible.

Date -_____

Personal History

Name: _____ Sex: ☐ Female ☐ Male

Marital status: ☐ single ☐ married ☐ divorced ☐ Widowed Date of Birth_____/_____/_____ (mm/dd/yyyy)

Address: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Social Security # : _____ Driver License #: _____ E-Mail: _____

Occupation _____ Employer _____

Height _____ Weight _____(lbs)

Referred by:_____

ALLERGIES: Like – Food, Pollens, Odors, Medicines, Pets etc…

_____

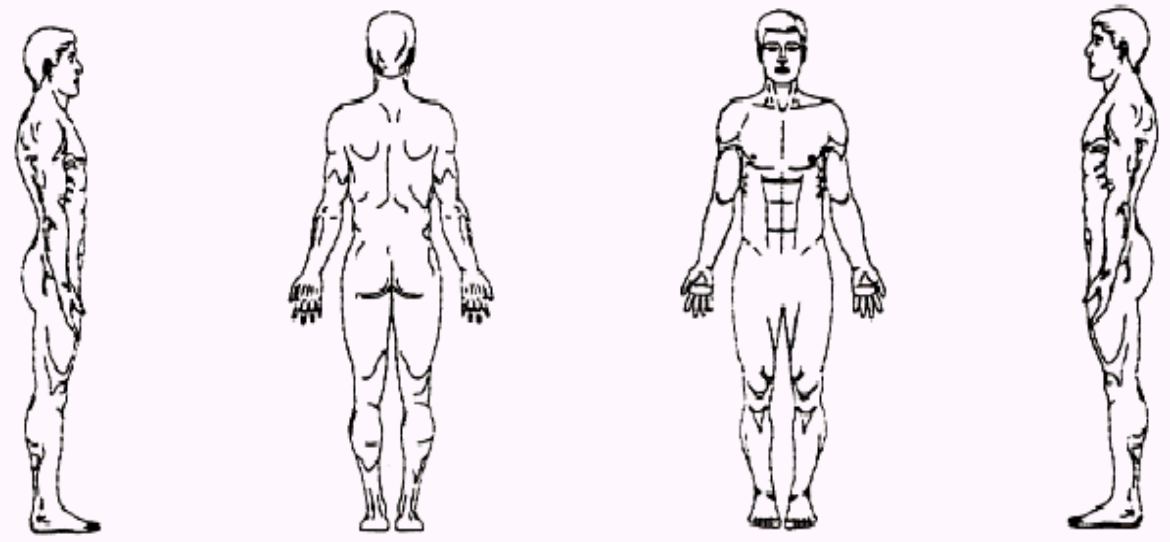
_____

_____

MAIN PROBLEMS/ REASONS FOR THIS CONSULTATION:

☐ Neck	☐ Back	☐ Right Shoulder	☐ Left Shoulder	☐ Right Elbow	☐ Left Elbow
☐ Right Wrist	☐ Left Wrist	☐ Right Hand	☐ Left Hand	☐ Right Hip	☐ Left Hip
☐ Right Thigh	☐ Left Thigh	☐ Right Knee	☐ Left Knee	☐ Right Ankle	☐ Left Ankle
☐ Right Foot	☐ Left Foot				

(On the diagram below, Please make a circle where you are experiencing pain, * for numbness or tingling right now.)



Other Symptoms:

□ Headaches	□ Buzzing in Ear	□ Fever	□ Light Bothers Eyes
□ Sleeping Problems	□ Ring in Ear	□ Stomach Upset	□ Loss of Memory
□ Nervousness	□ Loss of Balance	□ Diarrhea	□ Cold Hands
□ Dizziness	□ Fatigue	□ Constipation	□ Cold Feet
□ Pins & Needles in Arms	□ Fainting	□ Shortness of Breath	□ Irritability
□ Pins & Needles in Legs	□ Numbness in Fingers	□ Numbness in Toes	

SOCIAL HISTORY

Do you smoke cigarettes?	☐ YES ☐ NO	If yes, how many? #_____yrs. _____	packs per day
Did you ever smoke?	☐ YES ☐ NO	If yes, when did you quit? _____	
Do you drink alcohol?	☐ YES ☐ NO	If yes, how much? Type_____ & _____	drinks per week
Do you use recreational drugs?	☐ YES ☐ NO	If yes, which? _____	
Do you exercise regularly?	☐ YES ☐ NO	If no, why? _____	
Do you sleep soundly?	☐ YES ☐ NO	If no, why? _____	
Is your diet healthy enough?	☐ YES ☐ NO	☐ NOT SURE	☐ NEED HELP

CURRENT MEDICATIONS	Dose	Times / Day

CURRENT HERBS / VITAMINS/ HOMEOPATHY/ SUPPLEMENTS	Dose	Times / Day

PAST MEDICAL, SURGICAL & TRAUMA HISTORY

List prior illness, injury, hospitalization, surgery, and/or trauma:

Reason: Date/Month and Year

_____

_____

_____

HEALTH SCREENING HISTORY

List the date of your most recent test or exam

Anatomy\Procedure	X-ray	MRI	CT Scan	Ultrasound	Bone Scan	EKG	EEG
Back							
Brain							
Chest							
Colon							
Extremities (Arm/ Leg)							
Kidney							
Neck							
Stomach							
Other							

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
Allergies							
Arthritis							
Asthma							
Bleeding Disorder							
Cancer							
Depression							
Diabetes							
Epilepsy							
Heart Attack							
Heart Trouble							
High Blood Pressure							
Kidney Disease							
Liver Disease							
Migraine Headaches							
Stroke							
Other							

INSURANCE INFORMATION

Primary

Insurance Carrier: _____Phone: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder SS#: _____ Policy Number: _____

Group Number: _____ This is: Health Insur, Auto, Workers Comp, Other

_____

Secondary
Insurance Carrier: _____ Phone: _____
Policy Holder Name: _____ Policy Holder DOB: _____
Policy Holder SS#: _____ Policy Number: _____
Group Number: _____

CONSENT FOR TREATMENT
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

_____
Patient/ Guardian signature