

# Vail Ranch Family Chiropractic

## New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment.  
All information is strictly CONFIDENTIAL.

### Patient Information

Name \_\_\_\_\_ Email \_\_\_\_\_ Date \_\_\_\_\_  
(Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex  M  F

Occupation \_\_\_\_\_ Employer/School \_\_\_\_\_

Marital Status \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Spouse's SS# \_\_\_\_\_ Spouse's Birth date # \_\_\_\_\_

Emergency contact \_\_\_\_\_ Telephone # \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### Insurance Information

Who is responsible for this account? \_\_\_\_\_ Phone \_\_\_\_\_

Do you have health insurance?  Yes  No

Primary insurance company \_\_\_\_\_ Subscriber ID# \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Secondary insurance company \_\_\_\_\_ Subscriber ID# \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

### Accident Information

Is condition due to an accident?  Yes  No Date of injury/accident \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?

Auto Insurance  Employer  Work Comp.  Other \_\_\_\_\_

Adjuster Name / Attorney Name (if applicable) \_\_\_\_\_ Phone # \_\_\_\_\_

Claim # \_\_\_\_\_

### Assignment and Release

**ACKNOWLEDGMENT AND UNDERSTANDING:** I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I authorize the use of my signature on all insurance submissions. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be due and payable within 15 days. I authorize Vail Ranch Family Chiropractic to use my health care information and may disclose to above named insurance company(ies) for the purposes of obtaining payment for services and determining insurance benefits or the benefits payable for services.

\_\_\_\_\_  
PATIENT / GUARANTOR SIGNATURE

\_\_\_\_\_  
PRINTED NAME OF GUARANTOR  
(if other than patient)

/ \_\_\_\_\_  
RELATIONSHIP DATE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Current Complaints
Reason for visit _____
When did your symptoms appear? _____
Is this condition getting progressively worse? <input type="checkbox"/> Yes <input type="checkbox"/> No
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____
Type of pain: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Numbness <input type="checkbox"/> Aching <input type="checkbox"/> Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Cramps <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Other
How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with your <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Recreation
Activities or movements that are painful to perform <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Bending <input type="checkbox"/> Lying Down
Are your symptoms worse during certain times of the day? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had same condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____
List other practitioners seen for this injury/condition _____
What treatment have you already received for your condition? <input type="checkbox"/> Medications <input type="checkbox"/> Surgery <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Chiropractic Services <input type="checkbox"/> None <input type="checkbox"/> Other _____
Have you ever been under chiropractic care? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe _____
Are you interested in wellness care? <input type="checkbox"/> Yes <input type="checkbox"/> No

Medical History
Have you been treated for any conditions in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe _____
Date of last physical exam _____. Is there a chance that you are pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, due date _____
Have you had X-rays taken? <input type="checkbox"/> Yes <input type="checkbox"/> 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 condition, dosage, and frequency). _____ _____

Have you ever:	Yes	No	Briefly Explain
Broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in an auto accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Sprains/Strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Habits	None	Light	Moderate	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name: \_\_\_\_\_

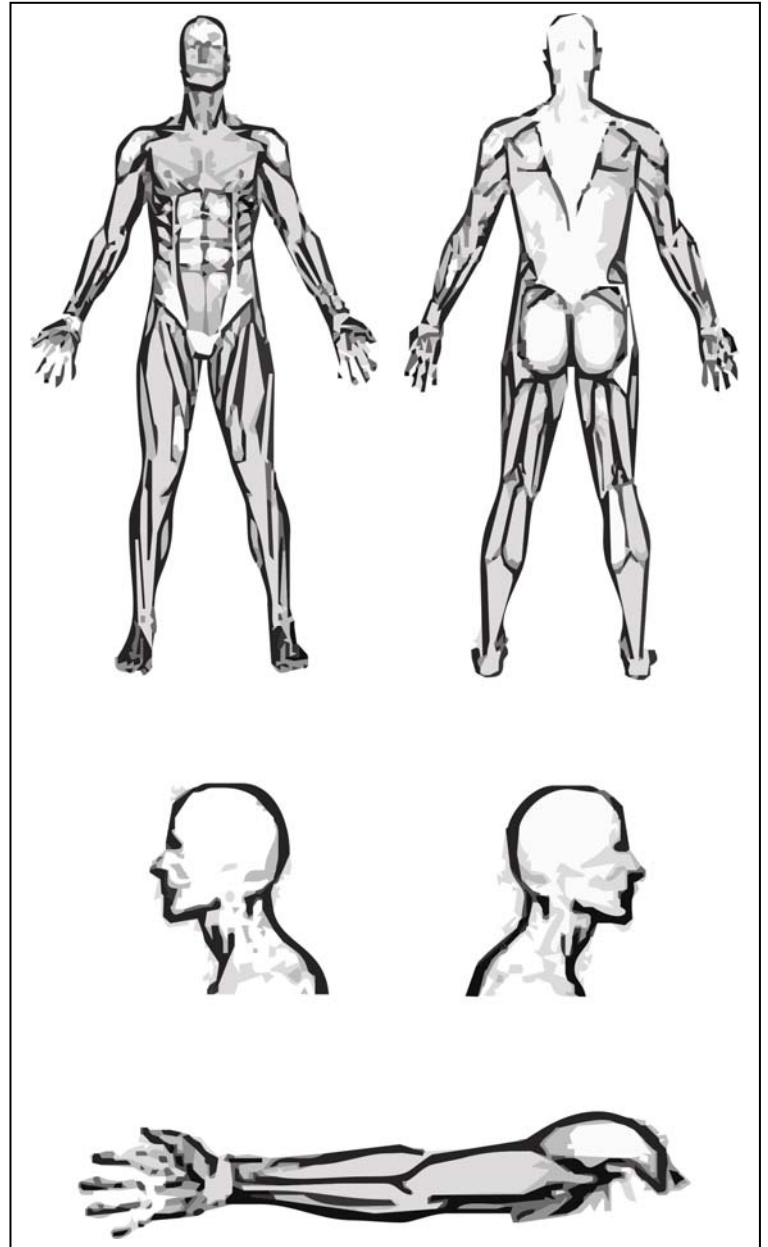
Date: \_\_\_\_\_

**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/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/insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

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



**Family History**

Family Members – Present & past health conditions

Example: (heart disease, cancer, diabetes, arthritis, etc.)

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