

# NEW PATIENT HEALTH HISTORY

Two options for completing this form:

- Please fill out on your computer, print it, and bring it to your first appointment.
- Please print out this form, then fill it out using a pen, and bring it to your first appointment.

**Note:** Regardless of the completion method selected above, the diagrams on page four and signatures on pages three, five, and six require you to use a pen to complete them. If you email us the form, this can be done in our office.



## Patient Contact Information

Patient's Full Name \_\_\_\_\_ Sex  F  M Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

E-mail \_\_\_\_\_

Parent or Guardian's Name (if patient under age 18) \_\_\_\_\_

Address \_\_\_\_\_ Apt. (if applicable) \_\_\_\_\_

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

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Contact Phone (\_\_\_\_\_) \_\_\_\_\_

Patient's Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Patient's Marital Status  Single  Married  Divorced  Widowed If Married, Spouse's Name \_\_\_\_\_

Number of Children \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Name of Referring Physician, Patient, or Family Member (if applicable) \_\_\_\_\_

## Insurance Coverage Information

Do You Have Health Insurance Coverage?  Yes  No\* If yes, please present your health insurance ID card when you arrive at our office for your first visit. We will make a photocopy of it for our files.

If insured, are you the primary name on the policy or is your spouse?  I am the primary name  My spouse is the primary name

If Spouse, Spouse's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Are You Enrolled in  Medicare  Medicaid? If you have Medicare supplemental insurance, please present your health insurance ID card when you arrive at the our of fice for your first visit. We will make a photocopy of it for our files.

Are you suffering from an auto accident injury that resulted in a claim?  Yes  No If yes, please bring the auto accident claim information received from your insurance agent. We will make a photocopy of it for our files.

\* If you do not have health insurance coverage, Advanced Family Chiropractic Center offers convenient payment plans that fit most budgets.

## Reasons for Seeking Care

Chief Complaint (include location) \_\_\_\_\_

Rate Intensity (0 = No Pain/Symptoms, 10 = Worst Possible Pain/Symptoms)  0  1  2  3  4  5  6  7  8  9  10

Secondary Complaint, if any (include location) \_\_\_\_\_

Rate Intensity (0 = No Pain/Symptoms, 10 = Worst Possible Pain/Symptoms)  0  1  2  3  4  5  6  7  8  9  10

Have You Ever Received Chiropractic Care?  Yes  No If Yes, When? \_\_\_\_\_

Nature of Injury  Automobile  Work  Other \_\_\_\_\_

Complaint(s) Began When & How? \_\_\_\_\_

## Reasons for Seeking Care (continued)

Description of the Complaint/Pain:  Dull  Aching  Sharp  Shooting  Burning  Throbbing  Deep  Nagging  
 Other Describe \_\_\_\_\_

Does This Pain Radiate or Travel (Shoot) to Any Other Areas of Your Body?  Yes  No If Yes, Where? \_\_\_\_\_

Do You Have Any Numbness or Tingling in Your Body?  Yes  No If Yes, Where? \_\_\_\_\_

How Frequent Is Complaint Present, How Long Does It Last? \_\_\_\_\_

Does Anything Aggravate the Pain? \_\_\_\_\_

Does Anything Make the Pain Better? \_\_\_\_\_

## Medical History

Your Height: \_\_\_\_\_ feet \_\_\_\_\_ inches Your Weight: \_\_\_\_\_ pounds

Previous Care for Your Complaint/Pain (Treatments, Medications, or Surgery You've Sought for Your Complaint) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have You Been Treated for Any Conditions in the Last Year?  Yes  No If Yes, What? \_\_\_\_\_  
\_\_\_\_\_

Approximate Date of Last Physical Exam \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Females: Could You Be Pregnant?  Yes  No  Not Sure

Have You Had X-Rays Taken in the Past Three Years?  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 Dosage and Amounts, and for What Condition, etc.) \_\_\_\_\_  
\_\_\_\_\_

Average Level of Stress in Your Life

No Stress  Very Little Stress  Some Occasional Stress  Moderate Stress  Significant Stress  High Stress  Severe Stress

### Disclaimer:

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

I authorize the release of any medical information necessary to process this claim and request payment of insurance benefits to be paid directly to Dr. John R. Owings or Advanced Family Chiropractic Center P.C. However, in the event that the insurance company does not pay for services provided by the doctor, I understand that all billable services will be transferred to me, the patient, for payment and I am responsible for payment of those services. Insurance co-pays and deductibles are due at time of service.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(If under 18, parent or guardian's signature)



# Your Personal Health Goals

At Advanced Family Chiropractic Center, we are not only here to help you with your current health issues, but also want to assist you in any way we can by helping you achieve a much higher level of wellness. To help me serve you in the best way possible, please share your personal goals with me. Together, we will look at these goals and make this your healthiest year yet!

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

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

My current physical activities include:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Basketball        | <input type="checkbox"/> Weight Training      | <input type="checkbox"/> Dance                   |
| <input type="checkbox"/> Baseball/Softball | <input type="checkbox"/> Running              | <input type="checkbox"/> Hockey                  |
| <input type="checkbox"/> Bicycling         | <input type="checkbox"/> Football             | <input type="checkbox"/> Martial Arts            |
| <input type="checkbox"/> Bowling           | <input type="checkbox"/> Treadmill/Elliptical | <input type="checkbox"/> Soccer                  |
| <input type="checkbox"/> Golf              | <input type="checkbox"/> StairMaster          | <input type="checkbox"/> Swimming/Water Aerobics |
| <input type="checkbox"/> Tennis            | <input type="checkbox"/> Yoga/Pilates         | <input type="checkbox"/> Walking                 |
| <input type="checkbox"/> Other: _____      |   |  |

I would feel so much better if I could ...

- |  |   |
|--|---|
| <input type="checkbox"/> Decrease my stress  | <input type="checkbox"/> Increase my flexibility        |
| <input type="checkbox"/> Decrease my anxiety   | <input type="checkbox"/> Strengthen my core muscles     |
| <input type="checkbox"/> Sleep better  | <input type="checkbox"/> Improve my posture             |
| <input type="checkbox"/> Have more energy  | <input type="checkbox"/> Improve workstation ergonomics |
| <input type="checkbox"/> Handle my food and/or outdoor allergies                     | <input type="checkbox"/> Quit smoking                   |
| <input type="checkbox"/> Lose weight. I would love to lose _____ pounds!             | <input type="checkbox"/> Eliminate caffeine             |
| <input type="checkbox"/> Eat healthier   | <input type="checkbox"/> Eliminate alcohol              |
| <input type="checkbox"/> Help with sugar cravings                                    | <input type="checkbox"/> Decrease fatigue               |
| <input type="checkbox"/> Start a personalized diet, organic diet or gluten-free diet | <input type="checkbox"/> Have more time with family     |
| <input type="checkbox"/> Lower my blood pressure                                     | <input type="checkbox"/> Have more time for myself      |
| <input type="checkbox"/> Lower my cholesterol  |   |
| <input type="checkbox"/> Lower my blood sugar  |   |
| <input type="checkbox"/> Learn sport-specific exercises. Sport: _____                |   |
| <input type="checkbox"/> Start a new sport/activity: _____                           |   |

Women Only:

- |  |  |
|--|--|
| <input type="checkbox"/> Decrease PMS symptoms       | <input type="checkbox"/> Decrease PCOS symptoms          |
| <input type="checkbox"/> Get pregnant                | <input type="checkbox"/> Decrease endometriosis symptoms |
| <input type="checkbox"/> Balance my hormones         |  |
| <input type="checkbox"/> Control menopausal symptoms |  |

Please brainstorm on any other health goals you have that I can assist you with:

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Thank you for sharing your most personal goals. I look forward to watching your great progress!