HEALTH HISTORY

GENERAL INFORMATION – Please print Date: _____ / _____ / _____

Patient Full Name: _____ Date of Birth: _____ / _____ / _____

Address: _____ care of: _____

City: _____ State: _____ Zip: _____ Phone (home) _____

Driver's Lic#: _____ No. Children: _____ Phone (work) _____

Spouse's Name:_____ Phone (cell) _____

Spouse's Employeer: _____ E-Mail: _____

Sex: M F Married / Single / Divorced / Widowed SS#: XXX-XX-_____

Patient's Employeer or School _____

Address _____

City _____ State _____ Zip _____

OCCUPATION: _____ Full time / Part Time

STUDENT: Full Time / Part Time

NOT EMPLOYED

RETIRED

Who may we thank for referring you:

_____

Children's Names:

_____

_____

_____

_____

POLICIES

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary at the expense of those who request them.
3. Method of payment you plan to use to take care of today's charges? Cash Check Credit Card

I understand and agree that health and accident insurance policies are an arrangement between my insurance carier and myself. Furthermore, I understand CORNERSTONE CHIROPRACTIC will prepare any necessary reports and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to CORNERSTONE CHIROPRACTIC will be credited to my account upon receipt, however, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

In case of emergency, notify _____ Relationship _____

Address _____ Phone Number (H) _____

_____ Phone Number (W) _____

_____ Phone Number (C) _____

CORNERSTONE CHIROPRACTIC NEW PATIENT HISTORY Please fill in appropriate spaces (confidential)

Name: _____ Date:_____

MAJOR COMPLAINT: _____

Have you lost work days? Yes / No If yes, how many? _____

When did you first notice the Complaint:_____ Date started: _____

Is this work/accident related? NO / Auto Accident / Work Accident If yes, when? _____

What makes the Complaint better: _____

What makes the Complaint worse: _____

Type of pain/complaint (eg: ache / burn / numb / tingling / stabbing / sharp / dull) _____

Location of the complaint (eg: right/left/center back/neck/arm/leg) _____

Is the complaint local or does it travel to other locations: _____

When do you notice the complaint: AM / PM Constant / Off and On _____

_____

Previous Chiropractic Care? Yes / No Chiropractor's / Clinic Name:_____

When was your last visit? _____ Reason for initial visit? _____

Was a spinal maintenance program given? Yes / No Did you Follow it? Yes / No

Why are you changing Chiropractors? _____

Previous Surgeries: _____

_____

Please list all drugs you now take (prescription and non-prescription) _____

_____

Other doctors seen for this condition: _____

What are your Health Goals? _____

How do you expect to achieve these goals? _____

Please mark if you have experienced any of the following:

____ Fractured bones
____ Auto accidents
____ 0-1 yrs ago
____ 1-5 yrs ago
____ 5 yrs or more
____ Other accidents/falls
____ Arthritis
____ Diabetes
____ Convulsions/epilepsy
____ Skin problems
____ Cancer
____ Frequent colds/flu
____ Depressed
____ Irritable
____ Anemia
____ Allergy, Sinus
____ Under stress
____ Eating disorders
____ Trouble Sleeping
____ Trouble Concentrating
____ Learning Disability

____ Mood Changes
____ Neck pain / stiffness R L
____ Numbness / tingling in arms, hands or fingers R L
____ Jaw pain / Clicks (TMJ) R L
____ Difficulty in excessive Standing, Sitting, riding, bending, twisting
____ Shoulder Pain R L
____ Dizziness
____ Ringing in ears R L
____ Hearing loss R L
____ Blurred / double vision
____ Upper back pain / stiffness
____ Mid back pain / stiffness
____ Low back pain / stiffness
____ Pain with cough / sneeze
____ Hip pain R L
____ Headaches
____ Numbness, tingling, pain In buttock / leg / feet R L

____ Foot trouble R L
____ Chest pain
____ Asthma
____ Heart problems
____ Stroke
____ High / Low blood pressure
____ Vericose veins
____ Liver trouble
____ Gall bladder trouble
____ Digestive problems
____ Ulcers
____ Hemorrhoids
____ Prostate problems
____ Impotence
____ Kidney trouble
____ Menstrual problems (PMS)
____ Pregnant (NOW)
____ Bed wetting
____ Ear Infections
____ AIDS / HIV