Billingsley Chiropractic Center Patient #__________

New Patient Health History Form

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

Patient Data

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

Mailing address

Address ____ City _______________ State ________
Zip _______ Telephone (work) ____________________ (home) ______________________
(cell)________________________
Referred By __________________________________
Age ________ Birth date ________________ Social Security # __________________
#of children ______________Occupation _______________________________
Employer____ Marital Status _____________
Spouse's name ___________________ Spouse's Occupation ___________________
Spouse's employer ____________________ Spouse's health status ________________
Emergency contact __________________________ Phone ______________________

Current Complaints

Nature of injury: Automobile* ❑ Work ❑ Other ❑
Please describe
____
____
Date of injury _____________ Date symptoms appeared _____________
Have you ever had same condition? ❑ No ❑ Yes If yes, when?
____
List other practioners seen for this injury/condition
____
Have you ever been under chiropractic care? ❑ No ❑ Yes
If yes, please describe
____

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Insurance Information

Name of party responsible for payment ________________________ Phone ________________________

Do you have health insurance? ❑ No ❑ Yes Name of company ___________________________

*** If an auto accident please provide:**

Insurance company name ________________________ Contact person ______________________________

Phone ______________________________ Claim # ____

Billing Address

Name of the insured ____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature ____ Date _________________

Spouse's or guardian's signature _____________________________ Date _________________

Medical History

Family Physician____Office Phone #_________________

Address____

Have you been treated for any conditions in the last year? ❑ No ❑ Yes

If yes, please describe ____

____

Date of last physical exam __________. Is there a chance that you are pregnant? ❑ No ❑ Yes

Have you had X-rays taken? ❑ No ❑ Yes 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 frequer

____

____

Have you ever:	No	Yes	Briefly Explain
Broken bones?	❑	❑	______________________________
Been hospitalized?	❑	❑	______________________________
Been in an auto accident?	❑	❑	______________________________
Had Sprains/Strains?	❑	❑	______________________________
Been struck unconscious?	❑	❑	______________________________
Had surgery?	❑	❑	______________________________

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Family History	
Family Member	**Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)**

Question	Answer
Do you experience pain every day?	❑ No ❑ Yes
Do your symptoms interfere with daily life?	❑ No ❑ Yes
Does pain wake you up at night?	❑ No ❑ Yes
Are your symptoms worse during certain times of the day?	❑ No ❑ Yes
Do changes in weather affect your symptoms?	❑ No ❑ Yes
Do you wear orthotics?	❑ No ❑ Yes
Do you take vitamin supplements?	❑ No ❑ Yes
What activities aggravate your symptoms?	❑ No ❑ Yes

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____
____

Habits	None	Light	Moderate	Heavy
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑
Soft Drinks	❑	❑	❑	❑
Water	❑	❑	❑	❑
Salty Foods	❑	❑	❑	❑
Sugary Foods	❑	❑	❑	❑
Artificial Sweeteners	❑	❑	❑	❑

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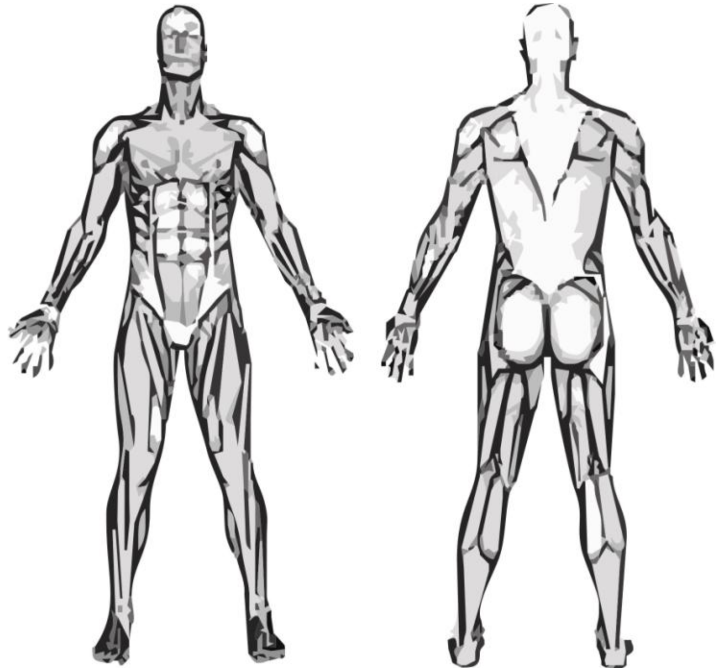
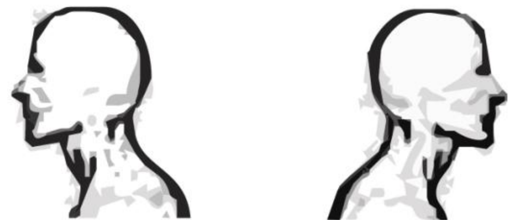
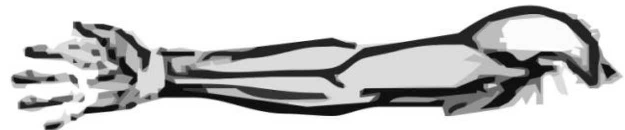
Have you ever suffered from:	
❑ Alcoholism ❑ Allergies ❑ Anemia ❑ Arteriosclerosis ❑ Arthritis ❑ Asthma ❑ Back Pain ❑ Breast lump ❑ Bronchitis ❑ Bruise Easily ❑ Cancer ❑ Chest Pain/Conditions ❑ Cold extremities ❑ Constipation ❑ Cramps ❑ Depression ❑ Diabetes ❑ Digestion Problems ❑ Dizziness ❑ Ears Ring ❑ 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   

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