Patient Health History Innate Health Chiropractic

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.

Today's Date: ________________

Patient Demographic Information:

Name: ____________________________________Birth Date: ____________ Age: _____ Gender: M/F

Address:________________________________ City: ________________State:_____ Zip:____________

Email Address: _______________________ Home Phone: _____________ Cell Phone: _____________

Occupation:________________________________ Employer:_____________________________________

Marital Status: __________________ Spouse's Name:____

Name & Number of Emergency Contact: ___________________________ Relationship: ____________

History of Complaint:

Please Identify the condition(s) that brought you to our office: Primary: ________________________

Secondary: ____________________Third: _________________________ Fourth: _________________

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by circling the number.

Primary or chief complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10

Second complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10

Third complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10

Fourth complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10

When did the problem(s) begin? ___________________ When is the problem at its worst? _________

I experience discomfort (please circle): All the time – Some of the time - Infrequently

How did this incident happen? ____

What relieves your symptoms? ____

What aggravates your symptoms? ____

Have you ever been treated for this condition in the past? Yes No If yes, when? _______________

Have you ever been under chiropractic care before? Yes No

Past History:

Have you suffered with this or a similar condition in the past? Yes No **If yes,** when was the last episode? ____

Have you tried other forms of treatment? Yes No **If yes,** what type of treatment? __________________________

__________________________________ How long ago? ____

Did you experience relief? Yes No

Please identify ALL PAST and CURRENT conditions you feel may be contributing to your present problem:

	How Long Ago	Type of Care Received
Injuries →		
Surgeries →		
Adult Diseases →		

Social History:

	None	Light	Moderate	Heavy
Alcohol Intake				
Smoking				
Exercise				
Sleep				
Water				
Caffeine				

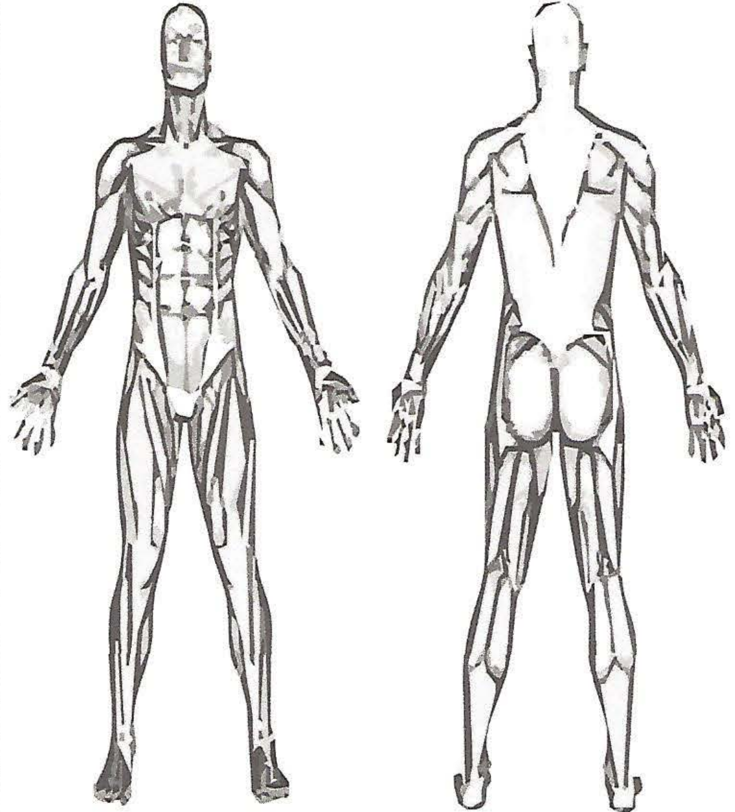
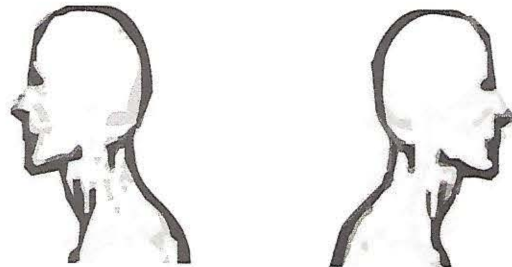
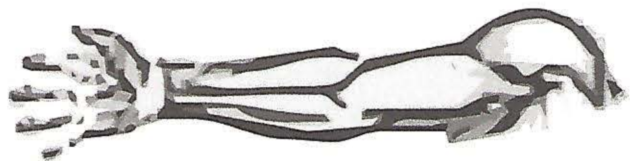
Family History:

Does anyone in your family suffer with the same condition? Yes No
If yes, whom? ____
Any family history of major medical diseases (heart disease, cancer, TB, diabetes)?
____

By signing, I verify that the information contained here is correct and accurate to the best of my knowledge. I authorize utilization of this application or copies thereof for the purposes of processing insurance claims. I further understand and agree that all services rendered to me and charged to me are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment with Innate Health Chiropractic, any fees for professional services rendered to me will be immediately due.

____ _______________________
Patient Name Date

____
Patient Signature (or Authorized Representative)

Have you ever suffered from:	Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.
☐ 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 or 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 or Insomnia ☐ Spinal Curvatures ☐ Stroke ☐ Swelling of ankles ☐ Swollen Joints ☐ Thyroid Condition ☐ Tuberculosis ☐ Ulcers ☐ Varicose Veins ☐ Venereal Disease ☐ Other: ______	**A**=Ache **O**=Other **B**=Burning **P**=Pins & Needles **N**=Numbness **S**=Stabbing   

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