Berven Chiropractic
6534 Gunn Hwy., Tampa, FL 33625
813-968-3500

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.

Date- / /

PATIENT NAME

First Name- Last Name- DOB- / /

CONTACT INFORMATION

Address- City- State- Zip-

Home ( ) Work ( ) Cell ( ) Email-

Preferred Contact-Home/Work/Cell/Email Emergency Contact Name- Phone-( )

PERSONAL INFORMATION

Gender- M F Marital Status- Single/Married/Widowed/Divorced/Legally Separated

Spouse Name- Preferred Language- English/Spanish/Other

Race- African American/Asian/Caucasian/Hispanic/Other- Hispanic or Latino Ethnicity? Yes/No

INSURANCE INFORMATION

Name of Primary Insured- DOB- / / SSN-

Phone Number- ( ) Relationship to Patient-

Employer Name- Work Phone- ( )

Work Address- City- State- Zip-

Insurance Company Name- Phone- ( )

Group Number- Employer Number- Deductible Met? Y / N

Do you have additional insurance (secondary)? Y / N If yes, please complete the following.

Insurance Company Name- Phone- ( )

Group Number- ID Number- Deductible Met? Y / N

SIGNATURES

Name of the Insured-

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand an 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 or Guardian Signature- Date-

REASON FOR VISIT

In your own words, please answer the following questions.

What is your reason for visiting us today?

When did your symptoms start?

What were you doing when they started?

Does any movement or position make you feel BETTER?

Does any movement or position make you feel WORSE?

Can you put what you're feeling into words? (sharp, stabbing, aching, etc.)

Does the feeling radiate to any other areas? Where?

Are your symptoms worse at any point in the day? (morning, evening, middle of night, etc.)

Have you ever experienced symptoms like this before? When?

Have you noticed any OTHER symptoms that seem to be related?

Please use the following scale to rate your symptom 0-10. 0 being no pain at all and 10 being the worst pain you can imagine.

What are your symptoms RIGHT NOW?	0	1	2	3	4	5	6	7	8	9	10
What are your symptoms AT THEIR WORST?	0	1	2	3	4	5	6	7	8	9	10
What are your symptoms AT THEIR BEST?	0	1	2	3	4	5	6	7	8	9	10

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MEDICAL HISTORY

Medications:

Name	Dosage (mg?)	Frequency	Duration (how long?)	Known Side Effects?

Major Traumas:

Type (check all that apply)		Date of Injury	Description including short-term and long-term effects
Car Accident	O		
Broken Bones	O		
Struck Unconcious	O		
Sprains/Strains	O		
Other: _____	O		
Other:	O		

Surgeries:

Date	Type of Surgery	Results of Surgery (fully recovered/continued symptoms?)

Hospitalizations:

Date	City	Hospital	Reason

Major Illness:

Date	Illness	Results of Illness (fully recovered/continued symptoms?)

Allergies:

Type	Reaction	Date of last episode

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Patient Name_____

Medical History Continued

Recent Testing:

Date	Type (X-Ray,CT,MRI,Labs,etc.)	Reason	Results	Testing Location

Family History:

Relationship	Age	Medical Condition(s)	Deceased?	Cause of Death
Father				
Mother				

Social History:

Lives With- Parents/Spouse/Alone **Smoking Status-** Never Smoked/Former Smoker/Current Smoker ___cigarettes/day

Alcohol- None/Casual/Moderate/Heavy **Caffeine-** ___drinks/day **Recreational Drugs-** None/Casual/Addict

___drinks/day or week **Exercise-** Never/Daily/Weekly **Type of Exercise-** Walk/Run/Swim/Gym/Other

Occupational History:

Employment Status- Employed/Unemployed/Retired/Student **Employer or School Name-** _____

Employment History

Company Name	Start Date	End Date	Description of Duties

ADDITIONAL INFORMATION

Have you ever suffered from: (check all that apply)

O Alcoholism	O Constipation	O Hemorrhoids	O Nosebleeds	O Thyroid Condition
O Allergies	O Cramps	O High Blood Pressure	O Pacemaker	O Tuberculosis
O Anemia	O Depression	O Hot Flashes	O Polio	O Ulcers
O Arteriosclerosis	O Diabetes	O Irregular Heart Beat	O Poor Posture	O Varicose Veins
O Arthritis	O Digestion Problem	O Irregular Cycle	O Prostate Trouble	O Venereal Disease
O Asthma	O Dizziness	O Kidney Infection	O Sciatica	O OSTEOPOROSIS
O Back Pain	O Ears Ringing	O Kidney Stones	O Scoliosis	O RHEUMATOID ARTHRITIS
O Breast Lump	O Excessive Menstruation	O Loss of Memory	O Shortness of Breath	O ABDOMINAL AORTIC ANEURYSM
O Bronchitis	O Excessive Thirst	O Loss of Balance	O Sinus Infection	O Other _____
O Bruise Easily	O Eye Pain/Problem	O Loss of Smell	O Sleep Trouble/Insomnia	
O Cancer	O Fatigue	O Loss of Taste	O Stroke	
O Chest Pain	O Frequent Urination	O Neck Pain/Stiffness	O Swelling of Ankles	
O Cold Arms/Legs	O Headaches	O Nervousness	O Swollen Joints	