New Patient Health History

Comprehensive health history intake for new chiropractic patients including spinal health and injury history

Client Information

First Name *

Last Name *

Email Address *

Phone Number *

Date of Birth *

MM / DD / YYYY

Referral Information

How did you hear about us?

- [ ] Physician referral
- [ ] Friend or family
- [ ] Insurance provider
- [ ] Online search
- [ ] Social media
- [ ] Other

Primary Care Physician

Physician Phone

Chief Complaint

What is your primary reason for visiting today? *

Where are you experiencing pain or discomfort? *

- [ ] Head / Headaches
- [ ] Neck
- [ ] Upper back
- [ ] Mid back
- [ ] Lower back
- [ ] Hip
- [ ] Left shoulder
- [ ] Right shoulder
- [ ] Left arm/hand
- [ ] Right arm/hand
- [ ] Left leg/foot
- [ ] Right leg/foot

Current pain level (0 = no pain, 10 = worst imaginable) *

- [ ] 0
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] 7
- [ ] 8
- [ ] 9
- [ ] 10

How would you describe the pain?

- [ ] Sharp
- [ ] Dull/Aching
- [ ] Burning
- [ ] Throbbing
- [ ] Shooting
- [ ] Tingling/Numbness
- [ ] Stiffness
- [ ] Constant
- [ ] Intermittent

When did this pain begin? *

- [ ] Today
- [ ] A few days ago
- [ ] A few weeks ago
- [ ] A few months ago
- [ ] More than a year ago

What caused or triggered the pain?

Injury & Accident History

Have you experienced any of the following?

- [ ] Car/motor vehicle accident
- [ ] Work-related injury
- [ ] Sports injury
- [ ] Slip and fall
- [ ] Heavy lifting injury
- [ ] Whiplash
- [ ] Bone fracture
- [ ] Spinal surgery
- [ ] None of the above

Please provide details about any injuries (dates, treatments received)

Have you received chiropractic care before? *

- [ ] Yes
- [ ] No

If yes, describe previous chiropractic treatment and outcomes

Medical Conditions

Do you currently have or have you been diagnosed with any of the following?

- [ ] Arthritis
- [ ] Osteoporosis
- [ ] Disc herniation or bulge
- [ ] Spinal stenosis
- [ ] Scoliosis
- [ ] Fibromyalgia
- [ ] Diabetes
- [ ] High blood pressure
- [ ] Cancer
- [ ] Stroke or TIA
- [ ] Pacemaker or implanted device
- [ ] None of the above

Current medications and supplements

Lifestyle & Daily Activities

Occupation

Your work primarily involves:

- ☐ Sitting at a desk
- ☐ Standing
- ☐ Physical labor
- ☐ Driving
- ☐ Mix of activities

How often do you exercise?

- ☐ Daily
- ☐ 3-5 times per week
- ☐ 1-2 times per week
- ☐ Rarely
- ☐ Never

How would you rate your sleep quality?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Consent & Signature

I certify that the above information is accurate and complete to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I agree to notify the office of any changes in my health status.

I confirm I have read and understood the above information and give my informed consent.

I have read and understand the above information: _____

Signature

Date

Print name

Date *

MM / DD / YYYY

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