New Patient Health History Form

Last _________________ First __________________ DOB ________ Age ____ Date ___________

Address __________________________________ City ________________ State ___ Zip ________

Phone (H) ____________ (C) ____________ Email ____

Occupation __________________________ Employer ______________________________________

Spouse's Name _______________ DOB ________ Phone ____________ Employer ______________

Have you had previous Chiropractic care? □yes □no Comments________________________________

How did you hear about us? ____________________ □Walk In □Google □MD □Other_____________

Name of Primary care physician? _________________ Phone ____________ Date of last exam _____

May we update your medical doctor regarding your treatment in our office? □yes □no

FINANCIAL INFORMATION

□Insurance □Self Pay (Cash) □Work Comp □Auto/Personal Injury □Other: _____________

[Primary Insured]: Name_______________ DOB _______ Ins Company________________Member ID_____________

[Secondary Insured]: Name_______________ DOB _______ Ins Company_______________Member ID_____________

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible

Current Complaint ___________________________ Date when symptom first appeared __________

How did it begin? ____

How often do you experience these symptoms?

□Constant 100% □Frequent 75% □Intermittent50% □Occasional 25% □Rare 10%

Have you ever experienced the same or similar symptoms □yes □no When? ______________

Have you been to another doctor for this problem? □yes □no Who/Where? ______________________

Have you ever been in an auto accident? □Past Year □Past 5 Years □Over 5 Years □Never

Please describe: ____

Please list ALL surgeries, injuries, accidents, falls etc: _______________________________________

____

List ALL Medications/Vitamins: ____

FAMILY HISTORY

Family Members – Present & Past health conditions (Ex: heart disease cancer, diabetes, etc.)

____

____

HABITS

Tobacco: □None □Light □Moderate □Heavy
Alcohol: □None □Light □Moderate □Heavy
Drugs: □None □Light □Moderate □Heavy
Coffee: □None □Light □Moderate □Heavy

Sleep: □None □Light □Moderate □Heavy
Exercise: □None □Light □Moderate □Heavy
Water: □None □Light □Moderate □Heavy
Soft Drinks: □None □Light □Moderate □Heavy

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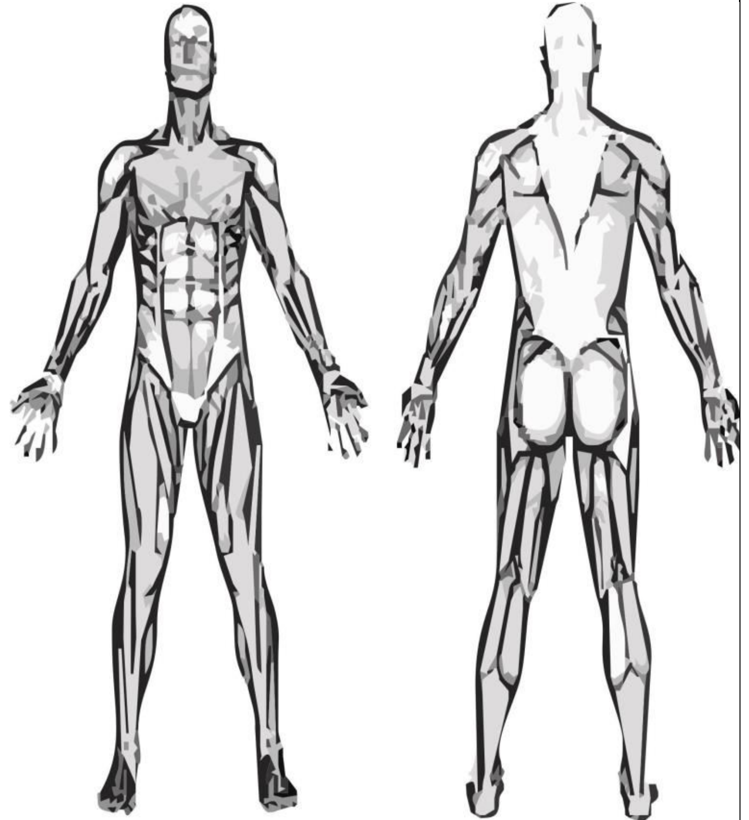
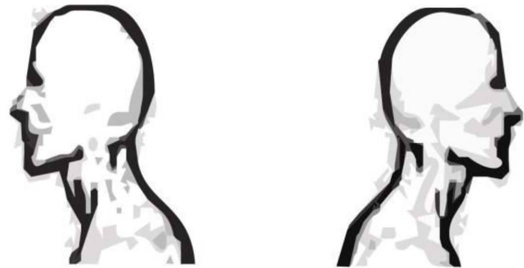
Have you ever suffered from:

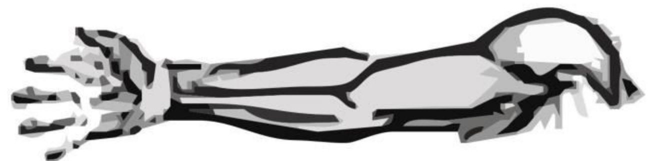
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain 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
- ☐ 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: ____________

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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Nester Chiropractic

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and
"Chiropractor" refers to Nester Chiropractic.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent by email or asking for one at the time of my next appointment.

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases the following may occur but not limited to fractures, disc injuries, strokes, dislocations and sprains. I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

______________________________ ______________________________

Signature of Patient or Personal Representative   Printed Name of Patient

______________________________ ______________________________

Date of Signing   Description of Personal Representative's Authority

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