COASTAL CHIROPRACTIC & WELLNESS
PATIENT HEALTH HISTORY

Name: ______________________________ (DOB) ___/__/___Gender: M F

Home Address: ______________________________ Cell Phone: ( ) ______________

City, State, Zip: ______________________________ Home Phone: ( ) ______________

Email: ______________________________ Marital Status: S M D W

Occupation: __________________________ Employer Name: ______________________

Names & Ages of Child____

Spouse's Name: _____________ Spouse's Employer:______________________ Occupation: ______________

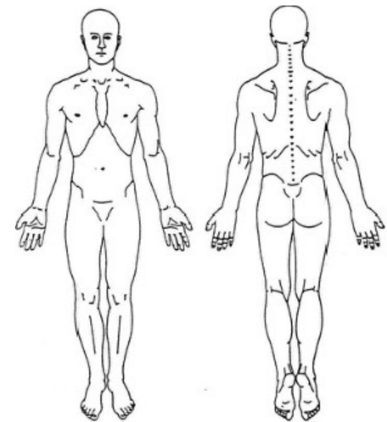
Whom may we thank for referring you to our office? ______________________________

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint:____

Secondary Complaint:____

Fill in all areas of discomfort on the figure to the right by using the following letters: **A** – aching **B** – burning **D** – dull **N** – numbness **R** – radiating **S** – sharp **T** – tingling



When did this condition begin? ____/_____/______

Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? ______________________________

Is there anything, which has relieved your symptoms? □ Yes □ No

Describe:______________________________

Does Pain Radiate into your: ___Arm ___Leg ___Doesn't radiate

Is this condition getting worse? □ Yes □ No

Who have you seen for this?_____________ What did they do? __________

How did you respond? ____

What kind of effect does your condition(s) have on the following? Check **all** that apply.

Bending	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Carrying	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Computer Work	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Concentration	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Doing Chores	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Driving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Exercising	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Playing Sports	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Running	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sitting / Standing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleeping	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Yard Work	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Working	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

What personal hobbies, work, or life activities does this effect? ______________________________

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? □ Yes □ No Who? ______________________ When? _______________
Reason for visits: _________________________________ How did you respond? _______________________________
Did your previous chiropractor take before and after x-rays? □ Yes □ No Results:__________________
Are you aware of any poor posture habits in your spouse or children? □ Yes □ No Explain: _________________

List all medications you currently use, the condition or reason for use, and the length of time on medication.
____
Please list all past surgeries: ____
Please list all previous accidents and falls: ____

LEVEL OF DESIRE

On a scale of **1 to 10** with 10 the highest, what is your level of desire to correct your problem without drugs or surgery? __

List any concerns that could interfere with your commitment (example: time, transportation, other)___________________

Please review the below listed symptoms, indicate those that are current health problems of a family member writing **C** ,the designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply.

	Father Age____	**Mother** Age____	**Spouse** Age____	**Brother**(s) Age____	Age____	**Sister**(s) Age____	Age____	**Children** Age____	Age____	Age____
First Name										
Condition										
Allergies										
Arthritis										
Auto Accidents										
Back Pain										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Headache										
Heartburn										
Heart Trouble										
High Blood Pressure										
Migraine										
Neck Pain										
Pinched Nerve										
Scoliosis										
Other:										

HIPPA

This office conforms to the current HIPPA guidelines. You may request a copy of our HIPPA policy at the front desk. Please initial to indicate you have been made aware of it's availability._______ **MUST INITIAL**

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation and administer any necessary care.

-I hereby authorize payment to made directly to Coastal Chiropractic & Wellness, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way receive me of payment liability and that I will remain financially responsible to Coastal Chiropractic & Wellness for any and all services I receive at this office.

-I allow this office to contact me via email, text message, or phone for scheduling/clinical need.
-This office uses a monthly to bimonthly email newsletter to keep our patients actively informed.
-I may opt-out via the email itself.

Authorization of the above may be retracted by notifying the office manager in writing.

Patient Signature: _________________________________ Guardian Signature: ___________________________