COASTAL CHIROPRACTIC & WELLNESS
HEALTH HISTORY

Name: _____ Todays Date: __/___/20__ (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: _____

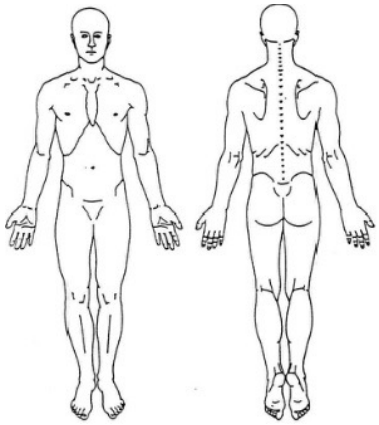
Whom may we thank for referring you to our office? _____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint:_____

Secondary Complaint:_____

Fill in <u>all</u> 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, cost, insurance)_____

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.

	SELF	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											
History of Stroke?											

HIPAA

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA 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: _____