PREMIER CHIROPRACTIC AND REHAB
Dr. Shane Henry

NEW PATIENT HISTORY

Name: _____ Home Phone: _____

Home Address: _____ Cell Phone: _____ Work Phone: _____

City, State, Zip: _____ E-mail Address: _____

Birth Date: ____/ ____/ ____ (Age) _____ Social Security #: _____/ _____/ _____ Gender: M F

Marital Status: S M D W Spouse's Name: _____ # of Children w/ Ages: _____

Occupations: _____ Employer Name: _____

Previous Chiropractic Care: Yes No Chiropractor's Name: _____ Last Visit: _____

Please check any health challenges you currently have or have experienced in the past 12 months:

__ Headache	__Feet/Hands cold	__Head seems heavy	__Pins & needles in arms right/left
__Mental Dullness	__Depression	__Confusion	__Pins & needles in hands right/left
__Loss of Memory	__Constipation	__Dizzy	__Pins & needles in legs right/left
__Unbalanced	__Neck Pain	__Neck Stiffness	__Chest Pain
__Rib Pain	__Fainting	__Shortness of breath	__Ears ringing/buzzing
__Upper Back Pain	__Upper Back Stiffness	__Mid Back Pain	__Mid Back Stiffness
__Lower Back Pain	__Lower Back Stiffness	__Blurred Vision	__Double Vision
__Neck Restriction	__Eye Strain/Pain	__Loss of Taste	__Loss of Smell
__Nervousness	__Fear	__Irritability	__Tension

Who may we thank for referring you to our office? _____ *Relationship:* _____

Name of primary care doctor? _____ Phone #: _____

Why are you seeking chiropractic care? _____

Briefly describe any health concerns: _____

Is this the result of an auto or work injury? _____ If so, when? _____

Does complaint(s) interfere with: ___Work __ Sleep __ Hobbies ___Daily Routine

Other doctors you have seen for this problem: _____

Spouse, parents, brother/sister, friends with similar health problems? _____

What are your health goals? _____

How do you expect to achieve these goals? _____

Have you been diagnosed with Cancer? Yes No

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement. I authorize the release of any information to process my insurance claims and request payment directly to my health care provider.

Patient Signature: _____ Date: _____

PREMIER CHIROPRACTIC AND REHAB

Dr. Shane Henry

3440 Division St., Suite G, Metairie, LA 70002

Office: 504-456-8560 Fax: 504-456-8562

PATIENT HISTORY

Date: _____ Last year of School Completed: _____ Ethnic Origin: _____

Name (Last) _____ (First) _____ M.I. ____ Birth Date: _____

ALLERGIES	ALLERGIC REACTIONS TO MEDICINE OR FOODS

CURRENT PRESCRIPTION MEDICATIONS	VITAMIN/HERBAL PREPARATIONS	OVER THE COUNTER MEDICATIONS

Tests & Immunizations (Indicate when and results)

Blood Profile _____
Breast Exam _____
Breast Mammography _____
Complete Blood Count _____
Chest X-Ray _____
Cholesterol/Triglycerides _____
Complete Physical _____
EKG _____
Enlarged Heart _____
Flu Shot _____
Genitalia Exam (Male) _____
Hearing Test _____
HIV Test _____
PAP (Smear) _____
Pneumonia _____
Pulmonary Function _____
Rectal Exam _____
Sigmoidscopy _____
Sodium & Potassium _____
Stool Occult Blood _____
Tetanus (DPT) _____
Treadmill Test _____
Urinalysis _____
Vision Test _____
Other _____

OPERATIONS

Tonsillectomy_____	Complications_____	Date_____
Appendectomy_____	Complications_____	Date_____
Hernia Repair_____	Complications_____	Date_____
Other_____	Complications_____	Date_____
Cholecystectomy_____	Complications_____	Date_____
Hysterectomy_____	Complications_____	Date_____
Other_____	Complications_____	Date_____
Radiation Therapy_____	Complications_____	Date_____

Name: _____ Date: _____

HOSPITALIZATIONS	Description	Hospital	Year
Illnesses (Kind)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Surgery (Kind)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Other (Reason)	_____	_____	_____

PERSONAL HABITS

Please answer honestly. This information is needed to assure the best possible treatment. All information is confidential. Please rate your answer on a scale of 1 to 5 (1= No/Never, 5 = Yes/Often).

	1	2	3	4	5	Elaborate
Exercise regularly						
Wear Seat Belts						
Use Illegal Drugs						
Drink Alcohol						
Smoke						
Chew or Dip Tobacco						
Experience Stress						
Other						

WOMEN ONLY **Menstrual Periods: Age of Onset_____ Regular?_____ Date Last Period Began_____**
Age Menopause _____ Difficulty with Periods? ___Yes ___No Specify_____
Number of Children: Born Alive_____ Cesarean_____ Stillborn_____ Miscarriages_____
Describe Complications:_____

Have you ever been referred to a specialist? ___Yes (Please Elaborate) ___No

_____
_____
_____

Have you ever been in an accident? ___Yes (Please Elaborate) ___No

_____
_____
_____

Are there any environmental risks involved in your job or home environment?__Yes (Please Elaborate) ___No

_____
_____
_____

MILITARY SERVICE

Which branch of service did you serve in? _____ Length of enlistment? _____ From_____ To_____
Did you sustain any injuries? ___Yes (Please Elaborate) ___No

_____
_____
_____

PERSONAL AND FAMILY HISTORY

Number of Brothers and Sisters_____

PERSONAL	YES	WHEN	YES	FAMILY SPECIFIC MEMBER
Abdominal Bleeding				
Allergies				
Anemia				
Arthritis				
Asthma/ Emphysema				
Back Disorders				
Bed Wetting				
Black Tarry Stools				
Bleeding Diseases				
Blood in Stool				
Blood in Urine				
Cancer				
Change in Bowel Habits				
Chest Pain				
Colitis				
Constipation				
Cough				
Coughing Blood				
Depression				
Diabetes				
Diarrhea				
Difficulty Swallowing				
Dizziness				
Enlarged Heart				
Double Vision				
Epilepsy				
Fainting Spells				
Gallstones				
Gall Bladder Disorder				
Glaucoma				
Headaches				
Heart Disease				
Heart Murmur				
Hepatitis				
Hoarseness				
High Blood Pressure				
Indigestion				
Irregular Heart Beat				
Kidney Infection				
Kidney Stone				
Leg Pain				
Lung Disease				
Lyme Disease				
Nosebleed				
Nervous Disorder				
Painful Urination				
Paralysis				
Phlebitis				
Pleurisy				
Pneumonia				
Pus in Urine				
Rheumatic Fever				
Stroke				
Swelling of feet				
Swollen/ Painful Joints				
T.B.				
Thyroid Disease				
Ulcer				