

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:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Feet/Hands cold | <input type="checkbox"/> Head seems heavy | <input type="checkbox"/> Pins & needles in arms right/left |
| <input type="checkbox"/> Mental Dullness | <input type="checkbox"/> Depression | <input type="checkbox"/> Confusion | <input type="checkbox"/> Pins & needles in hands right/left |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Constipation | <input type="checkbox"/> Dizzy | <input type="checkbox"/> Pins & needles in legs right/left |
| <input type="checkbox"/> Unbalanced | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Rib Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Ears ringing/buzzing |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Upper Back Stiffness | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Mid Back Stiffness |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Lower Back Stiffness | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Neck Restriction | <input type="checkbox"/> Eye Strain/Pain | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fear | <input type="checkbox"/> Irritability | <input type="checkbox"/> 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: _____

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						

<u>WOMEN ONLY</u> 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: _____
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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				