PREMIER CHIROPRACTIC AND REHAB Dr. Shane Henry

NEW PATIENT HISTORY

Name:	Home Phone:						
Home Address:							
City, State, Zip:		E-mail Address:					
Birth Date:/	/ (Age)	Social Security #:/	/ Gender: M F				
Marital Status: S M	D W Spouse's Name: _	# of C	hildren w/ Ages:				
Occupations:		Employer Name:					
Previous Chiropract	ic Care: Yes No Chirop	practor's Name:	Last Visit:				
Please check any he	alth challenges you curre	ntly 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 Stiffness	Mid Back Pain	Mid Back Stiffness				
	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 j	for referring you to our of	fice?	Relationship:				
Name of primary ca	re doctor?	Phone	#:				
Why are you seekin	g chiropractic care?						
Is this the result of a	n auto or work injury?	If so, when	?				
Does complaint(s) is	nterfere with:Work _	Sleep HobbiesDaily l	Routine				
Other doctors you h	ave seen for this problem:						
Spouse, parents, bro	ther/sister, friends with si	milar health problems?					
What are your health	h goals?						
	nosed with Cancer? Yes 1						
me in this office are my	sole responsibility, despite any		r understand that any charges incurred by or settlement. I authorize the release of any e provider.				

Patient Signature: _____ Date: _____

PREMIER CHIROPRACTIC AND REHAB

Dr. Shane Henry

826 Focis Street, Metairie, LA 70005 Office: 504-456-8560 Fax: 504-456-8562

PATIENT HISTORY

Date: Last ye	ar of School Completed:	Eth	Ethnic Origin:		
Name (Last)	(First)	M.I.	Birth Date:		
ALL	ERGIES	ALLERGIC REACT	TIONS TO MEDICINE OR FOODS		
CURRENT PRESCRIPT MEDICATIONS	TION VITAMIN/HER	BAL PREPARATIONS	OVER THE COUNTER MEDICATIONS		
Cholesterol/Triglycerides Complete Physical EKG Enlarged Heart		PAP (Smear) Pneumonia Pulmonary Function Rectal Exam Sigmoidscopy Sodium & Potassiu Stool Occult Blood Tetanus (DPT) Treadmill Test Urinalysis	on		
OPERATIONS Tonsillectomy Appendectomy Hernia Repair Other Cholecystectomy Hysterectomy Other Radiation Therapy	Complications Complications Complications Complications Complications		Date Date Date Date Date Date Date Date		

Name:						Date:			
HOSPITALIZATIONS Description llnesses (Kind)			Hospital			pital	Year		
Surgery (Kind)				 					
Other (Reason)				_					
PERSONAL HABITS Please answer honestly. The Please rate your answer on Exercise regularly Wear Seat Belts	is information a scale of 1 to	is ned 5 (1=	eded to	o assur lever,	re the 5 = Y	best p	oossible treatment en). Elaborate	. All information is confidential.	
Use Illegal Drugs Drink Alcohol Smoke Chew or Dip Tobacco									
Experience Stress Other									
WOMEN ONLY Began Age Menopause Number of Children: B Describe Complications Have you ever been referred	Difficu orn Alive ::	ılty w C	rith Pe Cesare	eriods? an	?	Yes _ Stillbo	_No Specify orn Miscar	riages	
	a to a specialis			_			ase Elaborate)		
Have you ever been in an a	ccident?			_	Ye	es (Ple	ase Elaborate)	_No	
Are there any environmenta	ıl risks involv	ed in	your jo	ob or h	iome	enviro	onment?Yes (Pl	ease Elaborate)No	
MILITARY SERVICE Which branch of service did Did you sustain any injuries	d you serve in	?(Plea	ise Ela	Le borate	ngth	of enli No	stment?	From To	

PERSONAL AND FAMILY HISTORY

Number of Brothers and Sisters_____

Abdornal Bleeding	PERSONAL	YES	WHEN	YES	FAMILY SPECIFIC MEMBER
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Back Disorders					
Bed Writing					
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Blood in Urine					
Cancer					
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