



776 W. Bartlett Road
 Bartlett, IL 60103
 630.837.3707

NEW PATIENT HEALTH & HISTORY FORM

Name: _____	Date: _____
Address: _____	SSN: _____
City: _____ State: _____ Zip: _____	Occupation: _____
Phone: Home: _____	Employer: _____
Work: _____	Driver's License Number: _____
Cell: _____	
E-Mail: _____	Marital Status: S M D W
Date of Birth: _____ (Age _____)	Spouse's Name: _____
Referred by: _____	Spouse's Occupation: _____

Number of Children and Ages

Previous Chiropractic Care?

Name: _____	Age _____	Yes _____	No _____	Reason _____
Name: _____	Age _____	Yes _____	No _____	Reason _____
Name: _____	Age _____	Yes _____	No _____	Reason _____
Name: _____	Age _____	Yes _____	No _____	Reason _____

You deserve to be healthy. When you were created, you were given the blueprints, intelligence, tools, and systems to live an active healthy lifestyle. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health. Through your examination and your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Circle All that Apply

	Patient	Spouse	Child #1	Child #2	Child #3	Chiropractor's Comments
1. Was Your Birth Traumatic?						
Long Delivery?	Y	Y	Y	Y	Y	_____
Difficult Delivery?	Y	Y	Y	Y	Y	_____
Forceps?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Breach/Cephalic?	Y	Y	Y	Y	Y	_____
Home Birth?	Y	Y	Y	Y	Y	_____
Mother given drugs during delivery?	Y	Y	Y	Y	Y	_____
Induced Labor?	Y	Y	Y	Y	Y	_____

2. Growth and Development

Did you ever once...	Patient	Spouse	Child #1	Child #2	Child #3	Chiropractor's Comments
Learn to care for your spine?	Y	Y	Y	Y	Y	_____
Fall out of bed?	Y	Y	Y	Y	Y	_____
Bang your head?	Y	Y	Y	Y	Y	_____
Breastfeed?	Y	Y	Y	Y	Y	_____
Have a childhood sickness?	Y	Y	Y	Y	Y	_____
Have any accidents?	Y	Y	Y	Y	Y	_____
Have surgery?	Y	Y	Y	Y	Y	_____
Take drugs?	Y	Y	Y	Y	Y	_____
Fall while learning to walk?	Y	Y	Y	Y	Y	_____
Bullied by your siblings?	Y	Y	Y	Y	Y	_____
Child abuse						
Spanking?	Y	Y	Y	Y	Y	_____
Pulled ear/chin	Y	Y	Y	Y	Y	_____
Other	Y	Y	Y	Y	Y	_____
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_____
Fall down the stairs?	Y	Y	Y	Y	Y	_____
Pulled by your arm?	Y	Y	Y	Y	Y	_____
Experience other traumas?	Y	Y	Y	Y	Y	_____

3. Current Health Habits

Did/do you...						
Smoke	Y	Y	Y	Y	Y	_____
Drink	Y	Y	Y	Y	Y	_____
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	_____
Have you been in accidents?	Y	Y	Y	Y	Y	_____
Have you had surgery and/or organs replaced/removed?	Y	Y	Y	Y	Y	_____
Drugs? (prescriptive or non-prescriptive)	Y	Y	Y	Y	Y	_____
Have teeth problems?	Y	Y	Y	Y	Y	_____
Have eye problems?	Y	Y	Y	Y	Y	_____
Have hearing problems?	Y	Y	Y	Y	Y	_____
Exercise Regularly?	Y	Y	Y	Y	Y	_____
Have sleeping problems? (nightmares)?	Y	Y	Y	Y	Y	_____
Have occupational stress?	Y	Y	Y	Y	Y	_____
Have physical stress?	Y	Y	Y	Y	Y	_____
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	_____
Sleeping posture:						
Side, stomach or back:	_____	_____	_____	_____	_____	_____

Current Health Condition

Present complaint or reason (be brief) for your visit today:

Major _____

Pain or Problem Started on _____

Pains are: Sharp Dull Constant Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other _____

Is this condition getting progressively worse? _____

Other doctors seen for this condition: _____

Any home remedies? _____

Females ONLY: When was your last period? _____ Are you pregnant? ____ Yes ____ No ____ Not Sure

Other Symptoms:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fever | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Buzzing in Ear |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Smell/Taste | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Foot Pain/Orthotics | <input type="checkbox"/> Depression |

Have you been under drug and medical care? _____

What medications are you taking? _____

How long? _____ Have you had surgery? _____ What? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

Is there a family history of:	Heart Disease	Arthritis	Cancer	Diabetes	Other	
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Upon completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

However, the patient or responsible party remains liable for any amount not paid by insurance, if any, within 30 days of our request for payment. In the event that payment is not timely made, and we must place the account for collections, you agree to pay all of our reasonable costs and expenses, including attorney fees, related to the collection of any sums due. A finance charge of 1.5% per month (Annual Percentage Rate 18.0%) will be added to the account, but the finance charge will not begin to accrue until thirty days after our request for payment.

I hereby authorize the doctor to treat my condition, as she deems appropriate. It is understood and agreed the amount paid for the doctor, for x-rays, is for examination only and the x-ray negatives will remain property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for payment of all bills incurred at this office.

As a result of my chiropractic care, I would like to:

(Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Feel better quickly | <input type="checkbox"/> Have a healthier body by keeping my nervous system healthy |
| <input type="checkbox"/> Have a healthier spine | <input type="checkbox"/> Live a healthier lifestyle |

Patient's Signature

Date

Consent to Treat a Minor

Date