## New Patient Health History Form

## In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

First Name	Patient Date	a					
Mailing address         Address       City       State       Zip         Idephone (Work]       [home]       Reterred By         Age       Birth Date       Social Security #       Number of Children         Occupation       Employer       Spouse's Name       Spouse's Occupation         Spouse's Employer       Spouse's Health Status       Spouse's Name       Spouse's Name         Spouse's Employer       Spouse's Health Status       Spouse's Mail       Spouse's Mail         Emergency Contact       Phone       Phone       Spouse's Mail         Current Complaints       Nature of Injury:       Automobile*       Work       Other         Please describe:	First Name	Last	Name	Date	e	Email*	
Address       City       Stote       Zip         Telephone (Work)       [Ihorme]       Referred by         Age       Birth Date       Social Security #       Number of Children         Occupation       Employer       Spouse's Name       Spouse's Occupation         Spouse's Employer       Spouse's Name       Spouse's Address       Spouse's Cocupation         Spouse's Employer       Spouse's Health Status       Emergency Contact       Phone         Current Complaints       Nature of Injury:       Automobile*       Work       Other         Please describe:       Date symptoms appeared       Have you ever had some condition? O No       Yes       If yes, when?         List of other practitioners seen for this injury/condition       Have you ever been under chiropractic care? O No       Yes         If yes, please describe       Insurance Information       Phone       Insurance Information         Name of party responsible for payment       Phone       Phone       Phone         Do you have health insurance? O No       Yes       Name of contact Person       Phone         Brone:       Claim #       Contact Person       Phone       Inderstand and agree that all services rendered to me and charged are my personal responsible for timely payment. 1 understand and agree that all services rendered to me and charged are my personal respo	*	Your email will NOT be s	hared with any 3rd (	 oarties, and is u	sed for occasio	 onal office annound	cements and promotions.
Address       City       State       Zip         Telephone (Work)       [fhome]       Referred By         Age       Birth Date       Social Security #       Number of Children         Occupation       Employer       Spouse's Name       Spouse's Occupation         Spouse's Employer       Spouse's Name       Spouse's Health Status       Emergency Contact         Marital Status       Spouse's Mame       Occupation       Spouse's Health Status       Emergency Contact         Date of Injury       Automobile*       Work       Other         Please describe:       Date symptoms appeared       Have you ever had some condition? O No       Yes         It yes, please describe       It yes, when?       It yes, when?       It yes, please describe         Is do ther practitioners seen for this injury/condition       Have you ever been under chiropractic care? O No       Yes         If yes, please describe       It yes, please describe       It yes, please describe       It yes, please describe         Insurance Information       Referred IN       Signatures       Contact Person       Phone         Signatures       Claim #       Contact Person       Phone       Inderstand and agree that all services rendered to me and charged are my personal responal prepres							
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professional services rendered to me will be immediately due and payable.		and myself.	I understand and agr	ee that all servic	es rendered to m	e and charged are m	y personal
Patient's signature Date Spouse's or guardian's signature Date		professional	services rendered to	me will be imme	diately due and p	ayable.	
Spouse s or guardian s signature         Date	Patient's sign	nature			Da	te	
	spouse's or (	yuaralan s signafur	≓		DC		

Medical History				
Have you been treated for any conditions	in the last year? O No O Yes			
If yes, please describe				
Date of last physical exam	Is there a chance that you are pregnant? $\bigcirc$ No $\bigcirc$ Yes			
Have you had X-rays taken? O No O Yes If Yes, where?				
What medications are you taking and for what conditions (Please list dosage and amounts, etc)I				
What vitaming minorals or borbs do you c	urrently take? (Please list for what conditions, dosage, and frequency).			
what what hims, minerals, of herbs do you c	orrenning takes (Flease list for what containons, absage, and frequency).			

Have you ever:	No Yes	Briefly Explain
Broken bones? Been hospitalized? Been in an auto accident? Had Sprains/Strains? Been struck unconscious? Had surgery?	000000	

## Family History Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	O No O Yes
Do your symptoms interfere with daily life?	O No O Yes
Does pain wake you up at night?	O No O Yes
Are your symptoms worse during certain times of the day?	O No O Yes
Do changes in weather affect your symptoms?	O No O Yes
Do you wear orthotics?	O No O Yes
Do you take vitamin supplements?	O No O Yes
What activities aggravate your symptoms?	

Habits	None	Light	Moderate	Heavy
Alcohol			$\bigcirc$	0
Coffee		IX	I X I	X
Tobacco	ΙΧ	I X	I X I	N N
Drugs	ΙŎ	ΙŎ	N N	Ň
Exercise	Ŏ	ΙÖ	Ŏ	Ŏ
Sleep	ΙÕ	ΙÕ	Õ	Õ
Appetite				
Soft Drinks				
Water				
Salty Foods		I Q	Q	Q
Sugary Foods	I Q	I Q	I Q I	l Q
Artificial Sweeteners				

Have you ever suffered from:	
Alcoholism	Please use the following letters to indicate TYPE and
	LOCATION of the symptoms you currently are experiencing.
Arteriosclerosis	A=Ache O=Other
Arthritis	<b>B</b> =Burning <b>P</b> =Pins & Needles
Asthma	N=Numbness S=Stabbing
Back Pain	N-NOTIBIESS 3-STABBIES
Breast Lump	
Bruise Easily	
Chest Pain/Conditions	
Cold Extremities	
Digestion Problems	
Dizziness	
$\square Ears Ring$	
Excessive Menstruation	
Eye Pain or Difficulties	
Frequent Urination	
High Blood Pressure	
Hot Flashes	
Irregular Heart Beat	
Irregular Cycle	
Kidney Infection	
Kidney Stones	
Loss of memory	
Loss of balance	
Loss of smell	
Loss of taste	
Lumps In Breast	
Neck Pain or Stiffness	
Nervousness	
Pacemaker	
Prostate Trouble	
Shortness of breath	
Sinus Infection	
Sleep problems or Insomnia	
Spinal Curvatures	
Stroke	
Swelling of ankles	
Swollen Joints	
Venereal Disease	
Other:	

Capitol Rehab

I, \_\_\_\_\_, understand and agree to the following:

\* I am responsible for paying all copays and deductibles at the time of service. It is my responsibility to pay for services and supplies to me by Capitol Rehab.

\* I hereby authorize Capitol Rehab to apply for benefits and/or covered services rendered in helping obtain payment from my insurance company. I authorize payment directly to Capitol Rehab and understand that I am ultimately financially responsible for my bill. If my insurance company denies payment for any reason, the amount will immediately become my responsibility.

I understand there is a \$25 fee for missed appointments cancelled without 24 hours notice.
 If I fail to meet my financial commitment to Capitol Rehab, and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account

including attorneys fees and collection agency fees associated with the proceedings.

Your email is also requested in order that Capitol Rehab can send you appointment reminders, newsletters and clinic information. You are not obligated to give the information if you do not wish to do so.

At Capitol Rehab, our business assoicate, our affiliated companies, we respect your privacy and the confidentiality of your personal information. In order to safeguard your privacy, we enforce the following privacy principles and inforamtion practies:

We respect your pirvacy and information about you and handle your data with care. You have the right to reivew you information, notify us of errors and omissions, and correct your personal information with care. We collect and maintain information to administer our business, and to provice products, services and information of importance to you. We provide security safeguards in the handling and maintenance of your information to protect against risks such as loss, destruction or misuse. We conduct periodic reviews to ensure proper secure handling and processing of your information. We do not sell individual information to unaffiliated third parties for marketing purposes.

Our information exchanges are within our trusted circle of affiliates and business associates and are designed to deliver products, sercies and information that are helpful to you. We require our business associates and affiliates to protect your privacy. We will enforce these principles. We hold our business associates and affiliates accountable for protecting your privacy.

I have read, understand and agree to the provisions of the above information.

Signature

Date \_\_\_\_

## EXAMINATION FORM

Name \_\_\_\_\_

Note Completed