BAYTOWN
BACK PAIN & HEALTH CENTER

NEW PATIENT HEALTH HISTORY FORM

PATIENT DATA

Last Name | Date

First Name | Middle Initial

Mailing Address – Line 1

Line 2

City | State

Zip

Home Phone | Work Phone

Cell Phone | E-mail

Emergency Contact | Emergency Number

Date of Birth | Sex

Social Security Number | Marital Status

Employer | Work Status

Work Phone

Insurance Name | Name of Insured

Insurance Mailing Address | Insured Social Security Number

Address Line 2 | Insured Date of Birth

City | State

Zip

Policy/Subscriber Number | Group Number

CURRENT COMPLAINTS

Nature of Injury: | Automobile ☐ Work ☐ Other ☐ (Specify other below)

Please Describe…

Date of Injury | Date Symptoms Appeared

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Have you ever had the same condition? Yes ☐ No ☐

If yes, when?

List other practitioners seen for this injury/condition…

Have you ever been under chiropractic care? Yes ☐ No ☐

If yes, please describe…

INSURANCE INFORMATION

Name of party responsible for payment… Phone Number

Do you have health insurance? Yes ☐ No ☐

Name of Company

If an auto accident, please provide…

Insurance Company Name Contact Person

Phone Number Claim Number

BILLING ADDRESS

Name of the Insured

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature Date

Spouse's or Guardian's Signature Date

MEDICAL HISTORY

Have you been treated for any conditions in the last year? Yes ☐ No ☐

If yes, please describe…

Date of last physical exam…

Is there a chance that you are pregnant? Yes ☐ No ☐

Have you had X-rays taken? Yes ☐ No ☐

What medications are you taking and for what conditions? (Please list dosage and amounts, etc.)

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency)

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Have you ever…

Broken bones?	Yes ☐ No ☐
Been hospitalized?	Yes ☐ No ☐
Been in an auto accident?	Yes ☐ No ☐
Had sprains/strains?	Yes ☐ No ☐
Been struck unconscious?	Yes ☐ No ☐
Had surgery?	Yes ☐ No ☐

If you answered yes to any of the above injuries, please explain further…

FAMILY HISTORY

Family Member	Present and past health conditions (Example: Heart Disease, Cancer, Diabetes, Arthritis, etc.)

HABITS

	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐

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SYMPTOMS (Please show where your symptoms are occurring in the diagram below)

- Bruise Easily ☐
- Cancer ☐
- Chest Pain/Conditions ☐
- Cold Extremities ☐
- Constipation ☐
- Cramps ☐
- Depression ☐
- Diabetes ☐
- Digestion Problems ☐
- Dizziness ☐
- Ears Ring ☐
- Excessive Menstruation ☐
- Eye Pain/Difficulties ☐
- Fatigue ☐
- Frequent Urination ☐
- Headache ☐
- Hemorrhoids ☐
- High Blood Pressure ☐
- Hot Flashes ☐
- Irregular Heartbeat ☐
- 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 ☐
- Nosebleeds ☐
- Pacemaker ☐
- Polio ☐
- Poor Posture ☐
- Prostate Trouble ☐
- Sciatica ☐
- Shortness of Breath ☐
- Sinus Infection ☐
- Sleep Problems/Insomnia ☐
- Spinal Curvatures ☐
- Stroke ☐
- Swelling of Ankles ☐
- Swollen Joints ☐
- Thyroid Condition ☐
- Tuberculosis ☐
- Ulcers ☐
- Varicose Veins ☐
- Venereal Disease ☐
- Other ☐