New Patient Health History Form

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

Patient Data

First Name | Last Name | Date | Email*

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address | City | State | Zip

Telephone (Work) | (home) | Referred By

Age | Birth Date | Social Security # | Number of Children

Occupation | Employer

Marital Status | Spouse's Name | Spouse's Occupation

Spouse's Employer | Spouse's Health Status

Emergency Contact | Phone

Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe:

Date if Injury | Date symptoms appeared

Have you ever had same condition? ◯ No ◯ Yes If yes, when?

List of other practitioners seen for this injury/condition

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

If yes, please describe

Insurance Information

Name of party responsible for payment | Phone

Do you have health insurance? ◯ No ◯ Yes Name of company

*** If an auto accident, please provide:**

Insurance Company Name | Contact Person

Phone: | Claim #

Signatures

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? ◯ No ◯ Yes

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? ◯ No ◯ Yes

Have you had X-rays taken? ◯ No ◯ Yes If Yes, where?

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

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, 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?	◯	◯	

Family History

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

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

What activities aggravate your symptoms?

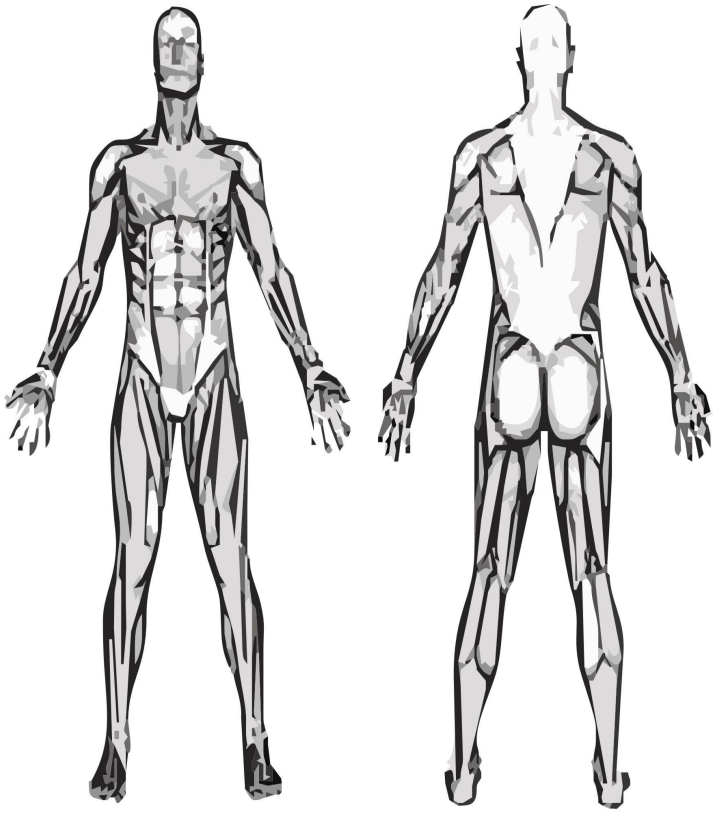
Habits	None	Light	Moderate	Heavy
Alcohol	◯	◯	◯	◯
Coffee	◯	◯	◯	◯
Tobacco	◯	◯	◯	◯
Drugs	◯	◯	◯	◯
Exercise	◯	◯	◯	◯
Sleep	◯	◯	◯	◯
Appetite	◯	◯	◯	◯
Soft Drinks	◯	◯	◯	◯
Water	◯	◯	◯	◯
Salty Foods	◯	◯	◯	◯
Sugary Foods	◯	◯	◯	◯
Artificial Sweeteners	◯	◯	◯	◯

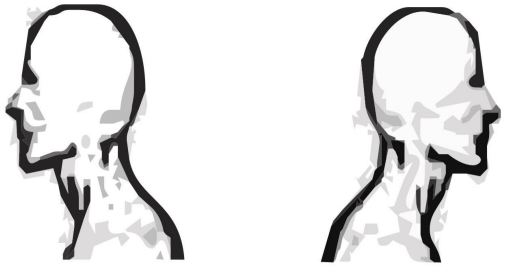
Have you ever suffered from:

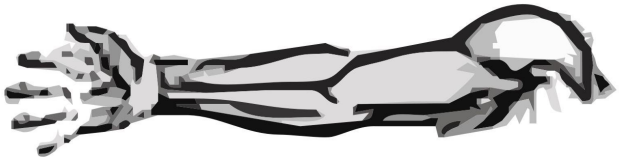
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ 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
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing







Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both parties to be working towards the same objective. Chiropractic care has only one goal. It is important that all patients understand both the objective and the methods that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment – An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health – A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation – A misalignment of one or more of the 24 vertebrae which causes alteration of the nerve function and interference to the transmissions of mental impulses, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider that specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. ***OUR ONLY OBJECTIVE*** is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statements. I therefore accept chiropractic care on this basis.

Patient Signature: _____ Date: _____

Authorization & Release

I authorize the following release of information to family physician, insurance company and employer, the taking of photographs and x-rays for treatment purposes, treatment of my minor children, my name and picture to be used for promotional purposes if asked by the doctors. I authorize my insurance benefits to be paid directly to Cagen Family Chiropractic, PLLC. Should I receive insurance payments directly, I will immediately present them to Cagen Family Chiropractic as payment.

Patient Signature: _____ Date: _____

X-Rays

Patients x-rays are the property of Cagen Family Chiropractic. They will be released only upon written request by the patient and paid in full. X-rays must be returned to Cagen Family Chiropractic within 30 days.

Payment Policies

Payment for your first day's services is due at the completion of your visit, if we are reimbursed by your insurance company, we will reimburse you or credit your healthcare account. We do not participate with ACN. If your insurance is under their umbrella, you may not be reimbursed or you may be reimbursed at a reduced rate. We will verify your insurance as a courtesy, however verification of benefits is not a guarantee of benefits. If you have any questions regarding your benefits, please contact your provider directly.

By signing, you acknowledge that you are financially responsible for all services rendered both covered and non-covered and also understand and agree that if you terminate care with this office, all fees due this office will become due and payable immediately.

Patient Signature: _____ Date: _____

Privacy Policies and Office Policies

Our office will hold your personal information in strict confidence and it will not release or be used in any way without your written permission. We do not make your personal information available to any outside source. Your information is secure and is used only in submitting claims to third party carriers for payment of services.

Our office may call you and leave a message on your home phone if it's necessary to contact you regarding an appointment or your care at our office.

Our office may send you seasonal cards or birthday cards.

A family member may be present when hearing the results of your exams and tests.

Our office has an open adjusting environment.

Please read the above statements and sign that you have been notified of our privacy policies. You have the right to revoke your agreement to our policies at any time in writing. A copy of our policies is available for your convenience.

I also understand that it may take up to 48 hours to verify insurance benefits. My insurance may have little or no benefits for these services. I am responsible for all charges and services rendered to me in this office.

I have read and agree to the above statements. Patient Signature: _____ Date: _____