Van Hemert Chiropractic
Pella, Iowa

NEW PATIENT HEALTH HISTORY

In order to provide you the best possible care, please complete this form and brint 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 3rd parties, and is used for occasional office announcements and promotions.

MAILING ADDRESS

Address ____ City _____________________ State ___________ Zip ______________

Telephone (cell) ____________________________ Work _____________________ Referred By ___________________________

Age ___________ Birth Date _________________________

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 of 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 ____________________

I certify that all information is accurate to the best of my knowledge

Spouse's or guardian's signature ____ Date ____________________

MEDICAL HISTORY

Have you been treated for any condition in the last year? ____ No ____ Yes

If yes, please describe ____

Date of last physical exam ____________________________ Is there a chance 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.)

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.)

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

What activities aggravate your symptoms?

HABITS	NONE	LIGHT	MODERATE	HEAVY
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				
Soft Drinks				
Water				
Salty Foods				
Artificial Sweeteners				

CASE HISTORY

1. Circle the severity (0=No Pain to 10=Very Severe Pain) and Frequency of pain (% of the week you experience the pain)

Condition / Problem	Severity (Minimal – Severe)	Frequency (Occasional – Constant)
a. ______	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. ______	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. ______	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. ______	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

2. Symptoms are worse in the (Circle what applies)

Morning	increase during the day
Afternoon	same all day
Night	decrease during the day

3. Symptoms (a Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins and Needles

4. Symptoms (b Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins and Needles

5. Symptoms (c Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins and Needles

6. Symptoms (d Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins and Needles

7. When did your symptoms begin (onset date)? ______

8. How did your symptoms begin? ______

9. Have you experienced these before? ______

10. Do your symptoms radiate? ______

11. Has your condition? ____ Improved ____ Gotten worse ____ Stayed the same since it began

12. Circle the things that make your problem worse:
    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

13. Is there anything you can do to relieve the problems? ___ Describe: ______

    If No, what have you tried that has not helped? ______

14. Have you been treated for this before? ___ No _ How long ago? ______

15. What treatment did you received? ______

16. Results of previous treatment: ____ Good ____ Comments: ______

17. Were you referred to our office by anyone? ______

18. Is this condition interfering with ____ Work _____ Sleep ____ Daily Routine ____ Recreation

19. List any other major injuries you have had, other than those mentioned above: ______

    ______

20. Any other musculoskeletal problems? ____ No ____ Yes Neurological problems? _____ No _____ Yes

HAVE YOU EVER SUFFERED FROM:

ð Alcoholism
ð Allergies
ð Anemia
ð Arteriosclerosis
ð Arthritis
ð Asthma
ð Back pain
ð Breast lump
ð Bronchitis
ð Bruise easily
ð Cancer
ð Chest pain/conditions
ð Cold extremities
ð Constipation
ð Cramps
ð Depression
ð Diabetes
ð Digestion problems
ð Dizziness
ð Ears ring
ð Excessive menstruation
ð Eye pain or difficulties
ð Fatigue
ð Frequent urination
ð Headache
ð Hemorrhoids
ð High blood pressure
ð Hot flashes
ð Irregular heart beat
ð Irregular cycle
ð Kidney infection
ð Kidney stones
ð Loss of memory
ð Loss of balance
ð Loss of smell
ð Loss of taste
ð Lumps in breast
ð Neck pain or stiffness
ð Nervousness
ð Nosebleeds
ð Pacemaker
ð Polio
ð Poor posture
ð Prostate trouble
ð Sciatica
ð Shortness of breath
ð Sinus infection
ð Sleep problems or insomnia
ð Spinal curvatures
ð Stroke
ð Swelling of ankles
ð Swollen joints
ð Thyroid condition
ð Tuberculosis
ð Ulcers
ð Varicose veins
ð Venereal disease
ð Other:

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

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