Pro Health
CHIROPRACTIC & MORE

New Patient Health History			
Name:			Today's Date:
Date of Birth:		Age:	☐Male ☐Female
Address:			
City:	State:		Zip:
Home Phone:	Cell Phone:		Email:
Best way to contact you: ☐Call Home ☐Call Cell ☐Text ☐Email			
Parent Name (If Minor):		Parent Phone Number:	

Referral Information
How did you hear about our office?

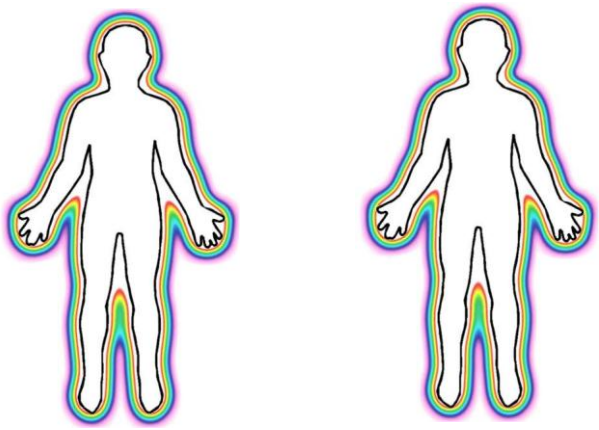
Emergency Information	
Emergency Contact:	
Phone:	Relationship:

Allergies/Current Medications
Please list any allergies & current Medications (or provide med list & we can copy):

Why Are You Here Today?	
Describe How it Feels	☐Sharp ☐Dull ☐Throbbing ☐Achiness ☐Discomfort ☐Dizziness ☐Headache ☐Losing Balance ☐Loss of flexibility ☐Muscle Spasms ☐Numbness ☐Sense of Unsteadiness ☐Stiffness ☐Swelling ☐Tenderness ☐Tightness ☐Tingling ☐Weakness

Please Circle Areas of Complaint. Use the following letters to describe your symptoms:

S – Stiffness
B – Burning
N – Numbness
P – Sharp Pain
T – Tingling
D – Dull Pain



FRONT BACK

How did the symptoms start?	
When did the symptoms start?	

When did they get worse?	
Has this happened before?	☐No ☐Yes If yes, When?:
When did you have symptoms last?	
Did a specific injury occur?	☐No ☐Yes If yes, When?:
Did a specific accident occur?	☐No ☐Yes If yes, When?:

Is this related to a work injury?	☐No ☐Yes See Additional Paperwork
Is this related to an auto accident?	☐No ☐Yes See Additional Paperwork
Pain Level Today	0 1 2 3 4 5 6 7 8 9 10
Pain Level Average	0 1 2 3 4 5 6 7 8 9 10
How often Do you Have Symptoms?	☐0-25% of the day ☐25-50% of the day ☐50-75% of the day ☐75-100% of the day
When are they worst?	☐Morning ☐Afternoon ☐Evening ☐Intermittent ☐Constant
Surgery History	Surgery: Date: Surgery: Date: Surgery: Date:
Review Of Systems Please Indicate (C – Current P – Past N – Never)	
Constitutional Symptoms	___Chills ___Fever ___Poor Appetite ___Weakness ___Weight Loss/Gain
Eyes	___Blurred Vision ___ Change in Vision ___Double Vision ___Pain
Ear/Nose/Throat/Mouth	___Difficulty Hearing ___Earaches ___Ear Infection ___Sinus Problem ___Snore ___Sore Throat
Cardiovascular	___Chest Pain ___Heart Murmur ___High Blood Pressure ___Irregular Heartbeat ___Swelling of legs ___Use of oxygen ___Varicose veins
Respiratory	___Blood in sputum ___Frequent cough ___Shortness of breath ___Wheezing
Gastrointestinal	___Abdominal pain ___Blood in stool ___Constipation ___Diarrhea ___Gluten intolerance ___Indigestion/Heartburn ___Jaundice ___Nausea/Vomiting ___Ulcers
Urinary	___Blood in Urine ___Discharge ___Painful urination ___Urinary frequency ___Urinary retention
Female specific	___Difficulty sleeping ___Hot flashes ___Vaginal dryness
Musculoskeletal	___Head Pain ___Neck Pain ___Low Back Pain ___Tailbone Pain ___Upper/Mid Back Pain ___Low Back Pain ___Tailbone Pain ___Shoulder Pain ___Arm Pain ___Elbow Pain ___Hand/Wrist Pain ___Hip Pain ___Leg Pain ___Knee Pain ___Foot/Ankle Pain ___Generalized Stiffness ___General Joint Pain ___Walking/Balance Problems ___Osteoporosis
Skin	___Boils ___Change in Skin Color ___Lump/Growth on Skin ___Persistent itch ___Skin rash
Neurological	___Dizzy Spells ___Headaches ___Loss of Balance ___Migraines ___Numbness/Tingling ___Tremors ___Ringing in ear ___Seizures ___Slurred Speech ___Stroke ___Weakness

Psychiatric	___Depression ___Memory loss/Forgetfulness
Endocrine	___Diabetes Type 1 ___Diabetes Type 2 ___Excessive Thirst ___Heat/Cold Intolerance ___Hypoglycemia ___Thyroid ___Tired/Sluggish ___Too hot/cold
Hematologic/Lymphatic	___Anemia ___Blood clotting problems ___Easy bruising/bleeding ___Enlarged lymph nodes ___Frequent bleeding from gums ___Swollen glands
Allergic/Immunologic	___Allergic reactions ___Anaphylaxis history ___Angioedema history ___Drug allergies ___Frequent injections ___Hay Fever ___Hepatitis ___HIV positive ___Positive for Tuberculosis ___Seasonal Allergies ___COVID

What Daily Activities does this condition affect? (Check All that apply)	☐Bending ☐Carrying ☐Climbing ☐Concentrating ☐Dancing ☐Chores ☐Computer Work ☐Dressing ☐Driving ☐Gardening ☐Lifting ☐ Sexual Activity ☐Sports ☐Pushing ☐Reading ☐Recreational Activity ☐Rolling over ☐Running ☐Shoveling ☐Sitting ☐Sitting ☐Sit to Stand ☐Sleeping ☐Standing ☐Walking ☐Watching TV ☐Working ☐Other (Please List) _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by the treating doctor, any fees for professional services will be immediately due and payable. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Signature: Date: