

**New Patient History Form**  
**Lewis Family Chiropractic & Wellness Center, P.A.**

Date: \_\_\_\_\_

**PATIENT INFORMATION**

FIRST NAME: _____			MIDDLE INITIAL: ___			LAST NAME: _____		
DOB: ___/___/___		SSN: ___ - ___ - ___		MALE/FEMALE (Circle one)		MARRIED/SINGLE/WIDOWED (Circle one)		
HOME #: _____			CELL #: _____			WORK #: _____		
HOME ADDRESS: _____								
CITY: _____			STATE: _____			ZIP _____		
HOW DID YOU HEAR ABOUT US: _____								

**EMERGENCY CONTACT**

FIRST NAME: _____			MIDDLE INITIAL: ___			LAST NAME: _____		
RELATION: _____			EMAIL: _____					
HOME #: _____			CELL #: _____			WORK #: _____		

**SOCIAL HISTORY**

<b>ALCOHOL</b> ___ Daily    ___ Weekly    ___ Occasionally    ___ Never
<b>DIET FOOD PRODUCTS</b> ___ Daily    ___ Weekly    ___ Occasionally    ___ Never
<b>OTC STIMULANTS</b> ___ Daily    ___ Weekly    ___ Occasionally    ___ Never
<b>HOMEMADE FOOD</b> ___ Daily    ___ Weekly    ___ Occasionally    ___ Never
<b>SOFT DRINKS</b> ___ Daily    ___ Weekly    ___ Occasionally    ___ Never
<b>WATER</b> ___ Daily    ___ Weekly    ___ Occasionally    ___ Never
<b>CAFFEINE</b> ___ Daily    ___ Weekly    ___ Occasionally    ___ Never
<b>DRUGS</b> ___ Daily    ___ Weekly    ___ Occasionally    ___ Never
<b>EXERCISE</b> ___ Daily    ___ Weekly    ___ Occasionally    ___ Never
<b>PROCESSED FOOD</b> ___ Daily    ___ Weekly    ___ Occasionally    ___ Never
<b>TOBACCO</b> ___ Daily    ___ Weekly    ___ Occasionally    ___ Never

**FAMILY HISTORY**

<b>DOES YOUR FAMILY HAVE ANY MEDICAL HISTORY THAT IS RELATED TO YOUR CONDITION?</b>
_____
_____
_____

# PERSONAL HEALTH HISTORY

PRIM. CARE PHYSICIAN: \_\_\_\_\_ PCP PHONE NUM.: \_\_\_\_\_

PCP ADDRESS: \_\_\_\_\_

LAST PHYSICAL EXAM: \_\_\_\_\_ ANY CHANCE OF PREGNANCY: \_\_\_ YES \_\_\_ NO

**MEDICATIONS:**

_____	_____	_____
_____	_____	_____
_____	_____	_____

**SUPPLEMENTS:**

_____	_____	_____
_____	_____	_____
_____	_____	_____

**BROKEN BONES:** \_\_\_ YES \_\_\_ NO EXPLAIN: \_\_\_\_\_

**SPRAINS / STRAINS:** \_\_\_ YES \_\_\_ NO EXPLAIN: \_\_\_\_\_

**HOSPITALIZED:** \_\_\_ YES \_\_\_ NO EXPLAIN: \_\_\_\_\_

**SURGERY:** \_\_\_ YES \_\_\_ NO EXPLAIN: \_\_\_\_\_

**AUTO ACCIDENT:** \_\_\_ YES \_\_\_ NO EXPLAIN: \_\_\_\_\_

**UNCONSCIOUSNESS:** \_\_\_ YES \_\_\_ NO EXPLAIN: \_\_\_\_\_

**EATING DISORDER:** \_\_\_ YES \_\_\_ NO EXPLAIN: \_\_\_\_\_

**STROKE:** \_\_\_ YES \_\_\_ NO EXPLAIN: \_\_\_\_\_

**HEART ATTACK:** \_\_\_ YES \_\_\_ NO EXPLAIN: \_\_\_\_\_

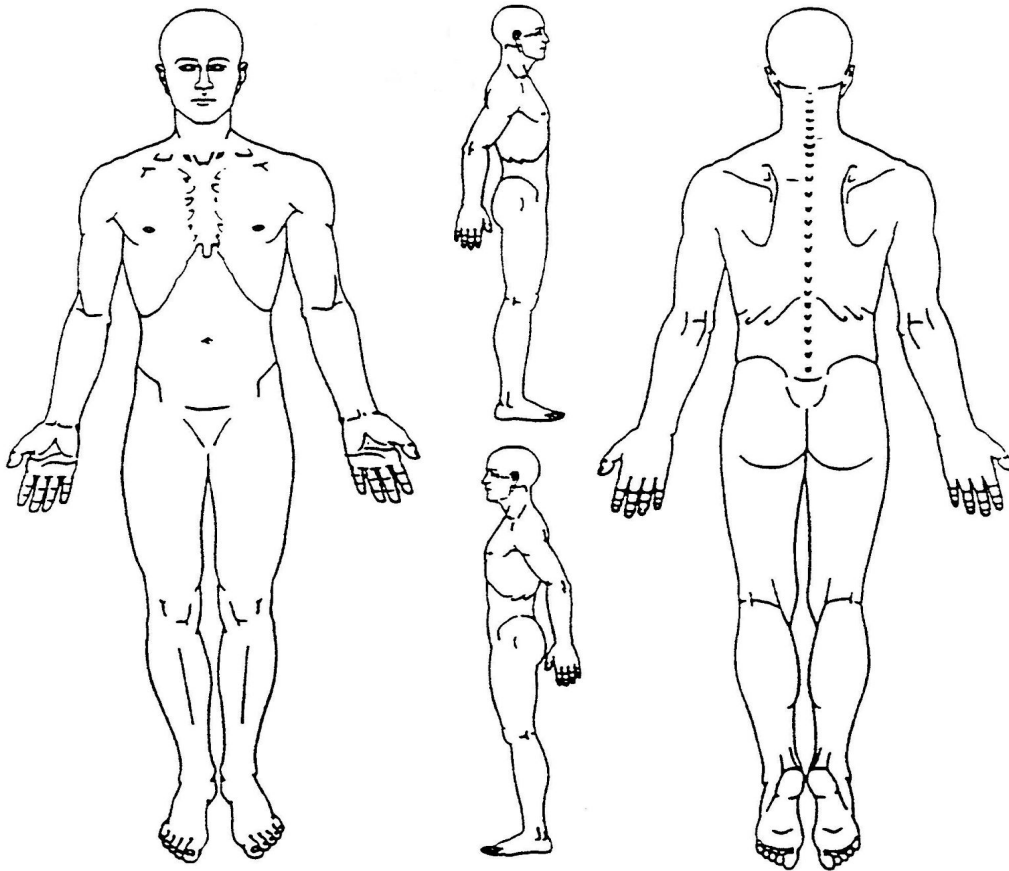
<ul style="list-style-type: none"> <li><input type="checkbox"/> Alcoholism</li> <li><input type="checkbox"/> Arteriosclerosis</li> <li><input type="checkbox"/> Autoimmune Disease</li> <li><input type="checkbox"/> Breast lump</li> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> CHF</li> <li><input type="checkbox"/> COPD/ Emphysema</li> <li><input type="checkbox"/> Dementia/ Alzheimer's</li> <li><input type="checkbox"/> Diagnosed Mental Disease</li> <li><input type="checkbox"/> Epilepsy</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Hemorrhoids</li> <li><input type="checkbox"/> Irregular Heart Beat</li> <li><input type="checkbox"/> Kidney Stones</li> <li><input type="checkbox"/> Cramps</li> <li><input type="checkbox"/> Spinal Curvatures</li> <li><input type="checkbox"/> Prostate trouble</li> <li> </li> <li><input type="checkbox"/> <i>None of the above</i></li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Loss of memory</li> <li><input type="checkbox"/> Lung disease</li> <li><input type="checkbox"/> Nosebleeds</li> <li><input type="checkbox"/> Polio</li> <li><input type="checkbox"/> Retinal disease</li> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Sleep problems</li> <li><input type="checkbox"/> Stroke</li> <li><input type="checkbox"/> Thyroid conditions</li> <li><input type="checkbox"/> Varicose veins</li> <li><input type="checkbox"/> Allergies</li> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Back pain</li> <li><input type="checkbox"/> Bronchitis</li> <li><input type="checkbox"/> Cataracts</li> <li><input type="checkbox"/> Cold Extremities</li> <li><input type="checkbox"/> Swollen joints</li> <li><input type="checkbox"/> Ulcers</li> <li><input type="checkbox"/> Parkinson's</li> <li> </li> <li><input type="checkbox"/> <i>None of the above</i></li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Digestion problems</li> <li><input type="checkbox"/> Excessive menstruation</li> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Gout</li> <li><input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> Irregular menstrual cycle</li> <li><input type="checkbox"/> Liver disease</li> <li><input type="checkbox"/> Loss of smell</li> <li><input type="checkbox"/> Macular degeneration</li> <li><input type="checkbox"/> Pacemaker</li> <li><input type="checkbox"/> Poor posture</li> <li><input type="checkbox"/> Sciatica</li> <li><input type="checkbox"/> Sinus infection</li> <li><input type="checkbox"/> Swelling of the ankles</li> <li><input type="checkbox"/> Tuberculosis</li> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> Skin sensitivity</li> <li> </li> <li><input type="checkbox"/> <i>None of the above</i></li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Venereal disease</li> <li><input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Bleeding disorder</li> <li><input type="checkbox"/> Frequent bruising</li> <li><input type="checkbox"/> Chest pain</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Stroke / TIA</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Eye pain</li> <li><input type="checkbox"/> Gallbladder disease</li> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Hot flashes</li> <li><input type="checkbox"/> Kidney infection</li> <li><input type="checkbox"/> Loss of balance</li> <li><input type="checkbox"/> Loss of taste</li> <li><input type="checkbox"/> Migraines</li> <li> </li> <li><input type="checkbox"/> <i>None of the above</i></li> </ul>
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**HAVE YOU HAD ANY OF THESE CARDIOVASCULAR DISEASES?** ( Select all that apply.)

<input type="checkbox"/> Myocardial infarction	<input type="checkbox"/> Bypass surgery	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Coronary artery disease
<input type="checkbox"/> Hypercholesterolemia			

**DO YOU HAVE DIABETES? IF SO, WHAT TYPE:** \_\_\_ Type I \_\_\_ Type II \_\_\_ Juvenile

**PATIENT SYMPTOMS** ( Circle where symptoms are on below diagram.)



**WHAT IS THE REASON FOR YOUR VISIT TODAY?** \_\_\_\_\_

**WHEN DID THIS START?** \_\_\_\_\_

**DOES THIS INTERFERE WITH WITH** \_\_\_ Work \_\_\_ Sleep \_\_\_ Daily Routine \_\_\_ Other \_\_\_\_\_

**Briefly Explain:** \_\_\_\_\_

**HAS THIS OCCURED BEFORE?** \_\_\_\_\_

Briefly Explain: \_\_\_\_\_

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS CONCERN? \_\_\_\_\_

Briefly Explain: \_\_\_\_\_

WAS THIS CONCERN DUE TO INJURY AT \_\_\_ Work \_\_\_ Automobile Accident \_\_\_ Other: \_\_\_\_\_

IF SO, WHEN DID THIS INJURY OCCUR? \_\_\_\_\_

Briefly Explain: \_\_\_\_\_

<b>Missed work</b> ___ YES ___ NO Dates: _____	<b>Interfere with activities</b> ___ YES ___ NO Briefly explain: _____
<b>Affected sleep</b> ___ YES ___ NO Briefly Explain: _____	<b>Affected appetite</b> ___ YES ___ NO Briefly Explain: _____
<b>Reduced Work</b> ___ YES ___ NO Briefly Explain: _____	<b>Does it worsen</b> ___ YES ___ NO Briefly Explain: _____
<b>Does the weather affect it</b> ___ YES ___ NO Briefly Explain: _____	<b>What aggravates this condition</b> Briefly Explain: _____
<b>What improves this condition</b> Briefly Explain: _____	<b>Have you received treatment before</b> ___ YES ___ NO Briefly Explain: _____
<b>Have you had any x-rays/ MRS's done</b> ___ YES ___ NO Briefly Explain: _____	<b>Pain Scale 1-10 with 10 being the worst</b> At it's worse _____ At it's best _____ Currently _____

I certify that I am the patient or the legal guardian of the patients information provided on this health history questionnaire. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I hereby authorize the doctor to release all information provided on this form as necessary to tany insurance company, attorney, or adjusted for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signes statement of authorization with my signature for required insurance submissions.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_