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

ALCOHOL ___ Daily ___ Weekly ___Occasionally ___ Never

DIET FOOD PRODUCTS ___ Daily ___ Weekly ___Occasionally ___ Never

OTC STIMULANTS ___ Daily ___ Weekly ___Occasionally ___ Never

HOMEMADE FOOD ___ Daily ___ Weekly ___Occasionally ___ Never

SOFT DRINKS ___ Daily ___ Weekly ___Occasionally ___ Never

WATER ___ Daily ___ Weekly ___Occasionally ___ Never

CAFFEINE ___ Daily ___ Weekly ___Occasionally ___ Never

DRUGS ___ Daily ___ Weekly ___Occasionally ___ Never

EXERCISE ___ Daily ___ Weekly ___Occasionally ___ Never

PROCESSED FOOD ___ Daily ___ Weekly ___Occasionally ___ Never

TOBACCO ___ Daily ___ Weekly ___Occasionally ___ Never

FAMILY HISTORY

DOES YOUR FAMILY HAVE ANY MEDICAL HISTORY THAT IS RELATED TO YOUR CONDITION?

_____

_____

_____

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:_____

- ❑ **Alcoholism**
- ❑ **Arteriosclerosis**
- ❑ **Autoimmune Disease**
- ❑ **Breast lump**
- ❑ **Cancer**
- ❑ **CHF**
- ❑ **COPD/ Emphysema**
- ❑ **Dementia/ Alzheimer's**
- ❑ **Diagnosed Mental Disease**
- ❑ **Epilepsy**
- ❑ **Fatigue**
- ❑ **Glaucoma**
- ❑ **Hemorrhoids**
- ❑ **Irregular Heart Beat**
- ❑ **Kidney Stones**
- ❑ **Cramps**
- ❑ **Spinal Curvatures**
- ❑ **Prostate trouble**

❑ ***None of the above***

- ❑ **Loss of memory**
- ❑ **Lung disease**
- ❑ **Nosebleeds**
- ❑ **Polio**
- ❑ **Retinal disease**
- ❑ **Shortness of breath**
- ❑ **Sleep problems**
- ❑ **Stroke**
- ❑ **Thyroid conditions**
- ❑ **Varicose veins**
- ❑ **Allergies**
- ❑ **Arthritis**
- ❑ **Back pain**
- ❑ **Bronchitis**
- ❑ **Cataracts**
- ❑ **Cold Extremities**
- ❑ **Swollen joints**
- ❑ **Ulcers**
- ❑ **Parkinson's**

❑ ***None of the above***

- ❑ **Depression**
- ❑ **Digestion problems**
- ❑ **Excessive menstruation**
- ❑ **Frequent urination**
- ❑ **Gout**
- ❑ **High blood pressure**
- ❑ **Irregular menstrual cycle**
- ❑ **Liver disease**
- ❑ **Loss of smell**
- ❑ **Macular degeneration**
- ❑ **Pacemaker**
- ❑ **Poor posture**
- ❑ **Sciatica**
- ❑ **Sinus infection**
- ❑ **Swelling of the ankles**
- ❑ **Tuberculosis**
- ❑ **Seizures**
- ❑ **Skin sensitivity**

❑ ***None of the above***

- ❑ **Venereal disease**
- ❑ **Anemia**
- ❑ **Asthma**
- ❑ **Bleeding disorder**
- ❑ **Frequent bruising**
- ❑ **Chest pain**
- ❑ **Constipation**
- ❑ **Stroke / TIA**
- ❑ **Diabetes**
- ❑ **Dizziness**
- ❑ **Eye pain**
- ❑ **Gallbladder disease**
- ❑ **Headaches**
- ❑ **Hot flashes**
- ❑ **Kidney infection**
- ❑ **Loss of balance**
- ❑ **Loss of taste**
- ❑ **Migraines**

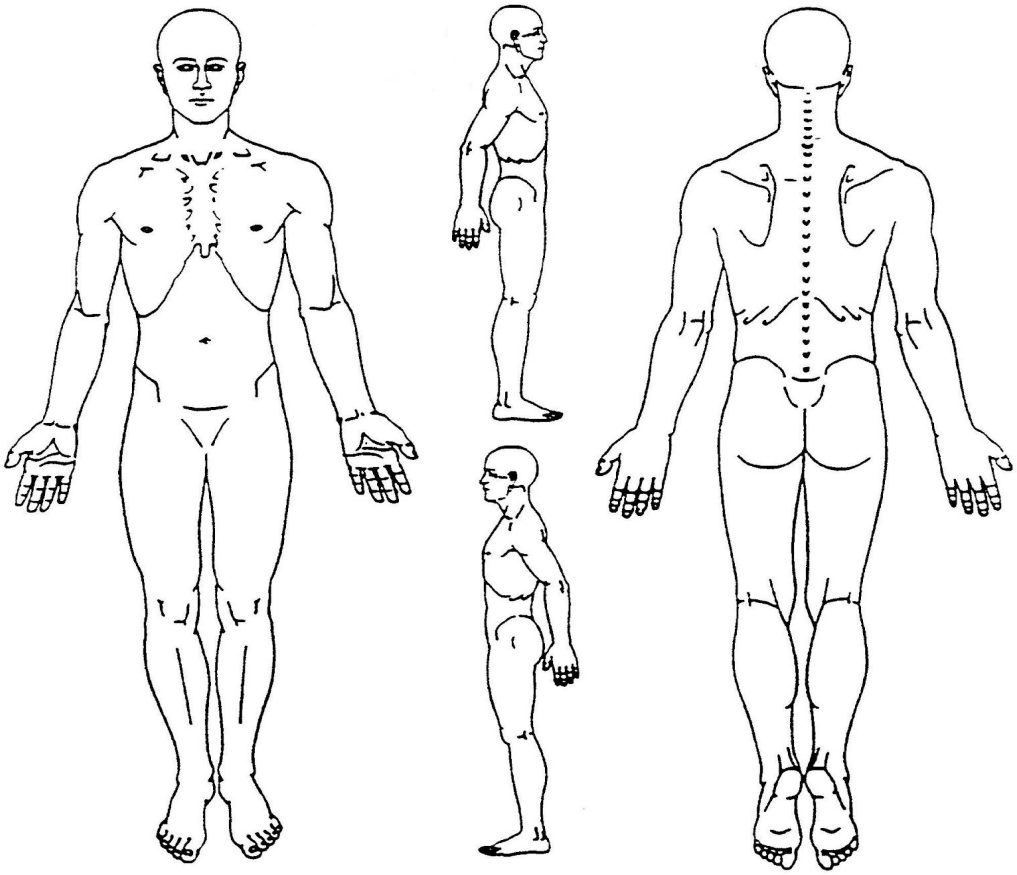
❑ ***None of the above***

HAVE YOU HAD ANY OF THESE CARDIOVASCULAR DISEASES? **(Select all that apply.)**

❑ **Myocardial infarction**	❑ **Bypass surgery**	❑ **Hypertension**	❑ **Coronary artery disease**
❑ **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?_____

Breifly Explain:_____

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