SCHLUTER CHIROPRACTIC

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DrSchluter.com

New Patient Health History Form

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential
We comply with all federal privacy standards. Please print clearly.

Today's Date:_____
(mm/dd/yyyy)

PATIENT INFORMATION

*Patient Name:*_____ *What do you prefer to be called:*_____
Last First MI

*Birth Date:*_____ *Age:*_____ *Gender:* ☐ *Male* ☐ *Female* *Social Security #:*_____
(mm/dd/yyyy)

*Address:*_____ *City:*_____ *State:*_____ *Zip:*_____

*Home Phone:*_____ *Cell Phone:*_____ *Email:*_____

*Whom May We Thank For Referring You:*_____ *Text/Email Appointment Reminders:* ☐ *Yes* ☐ *No*

*Occupation:*_____ *Employer:*_____ *How Long:*_____

*Work Phone:*_____ *Ext:*_____ *May We Contact You At Work:* ☐ *Yes* ☐ *No*

Marital Status: ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated* *Spouse's Name:*_____ *# of Children:*_____

*Emergency Contact:*_____ *Relation:*_____ *Phone #:*_____

INSURANCE INFORMATION

☐ *Not Applicable* ☐ *See Insurance Card Copy*

*Insurance Carrier:*_____ *Phone:*_____

*Address:*_____ *City:*_____ *State:*_____ *Zip:*_____

*ID #:*_____ *Policy/Group #:*_____

*Insured's Name:*_____ *Birth Date:* _____ *Relation:*_____
Last First MI *(mm/dd/yyyy)*

ABOUT YOU

What is your approximate height: _____' _____" *and weight* _____ *lbs.* ***FOR WOMEN:*** *Pregnant:* ☐ *Yes* ☐ *No* _____*wks.*
Nursing: ☐ *Yes* ☐ *No*

Exercise:
☐ *None*
☐ *Moderate*
☐ *Daily*
☐ *Heavy*

*Type:*_____
_____

Work activity:
☐ *Sitting*
☐ *Standing*
☐ *Light labor*
☐ *Heavy labor*

Habits:
Alcohol use ☐ *Daily* ☐ *Weekly* *How much?*_____
Coffee use ☐ *Daily* ☐ *Weekly* *How much?*_____
Tobacco use ☐ *Daily* ☐ *Weekly* *How much?*_____
Pain relievers ☐ *Daily* ☐ *Weekly* *How much?*_____
Soft drinks ☐ *Daily* ☐ *Weekly* *How much?*_____
Water intake ☐ *Daily* ☐ *Weekly* *How much?*_____
High stress level ☐ *Yes* ☐ *No* *Reason:*_____

HEALTH HISTORY

Have you ever suffered from any of these conditions past or present?:

Past	Present		Past	Present		Past	Present		Past	Present		Past	Present	
☐	☐	Acne	☐	☐	Dizziness	☐	☐	Headache	☐	☐	Low blood pressure	☐	☐	Rash
☐	☐	Angina	☐	☐	Eczema	☐	☐	Hearing loss	☐	☐	Low energy	☐	☐	Ringing in ears
☐	☐	Anorexia/bulimia	☐	☐	Elbow/wrist pain	☐	☐	Heartburn	☐	☐	Low libido	☐	☐	Scoliosis
☐	☐	Apnea	☐	☐	Emphysema	☐	☐	High blood pressure	☐	☐	Neck pain	☐	☐	Shortness of breath
☐	☐	Arthritis	☐	☐	Erectile dysfunction	☐	☐	High cholesterol	☐	☐	Numbness	☐	☐	Shoulder problems
☐	☐	Asthma	☐	☐	Excessive bruising	☐	☐	Hip disorders	☐	☐	Osteoporosis	☐	☐	Skin cancer
☐	☐	Anxiety	☐	☐	Fainting	☐	☐	Hypoglycemia	☐	☐	Pins and needles	☐	☐	Sudden weight change
☐	☐	Bedwetting	☐	☐	Fatigue	☐	☐	Immune disorders	☐	☐	PMS symptoms	☐	☐	Swollen glands
☐	☐	Blurred Vision	☐	☐	Food sensitivities	☐	☐	Infertility	☐	☐	Poor appetite	☐	☐	Thyroid issues
☐	☐	Ear infection	☐	☐	Foot/ankle pain	☐	☐	Kidney stones	☐	☐	Poor circulation	☐	☐	TMJ issues
☐	☐	Constipation	☐	☐	Frequent infection	☐	☐	Knee injuries	☐	☐	Poor Posture			
☐	☐	Depression	☐	☐	Hair loss	☐	☐	Loss of smell	☐	☐	Prostate issues			
☐	☐	Diarrhea	☐	☐	Hay Fever	☐	☐	Loss of taste	☐	☐	Psoriasis			

Past	Present		Past	Present		Past	Present		Past	Present		Past	Present	
☐	☐	AIDS	☐	☐	Chicken pox	☐	☐	Goiter	☐	☐	Multiple Sclerosis	☐	☐	Stroke
☐	☐	Alcoholism	☐	☐	Diabetes	☐	☐	Gout	☐	☐	Mumps	☐	☐	Tuberculosis
☐	☐	Allergies	☐	☐	Eczema	☐	☐	Heart disease	☐	☐	Pneumonia	☐	☐	Typhoid fever
☐	☐	Arteriosclerosis	☐	☐	Emphysema	☐	☐	Hepatitis	☐	☐	Polio	☐	☐	Ulcer
☐	☐	Arthritis	☐	☐	Epilepsy	☐	☐	Malaria	☐	☐	Rheumatic fever			
☐	☐	Cancer	☐	☐	Glaucoma	☐	☐	Measles	☐	☐	Scarlet fever			

Have you had any injuries in the past?:

☐ Fractured or broken bone ☐ Spine or nerve disorder ☐ Knocked unconscious ☐ Injured in an accident (car, sports, work)

☐ Used a crutch or other support ☐ Used neck or back bracing ☐ Other:_____

Have you had any operations/surgeries?:

☐ Appendix removed ☐ Bypass surgery ☐ Cancer surgery ☐ Eye surgery ☐ Spine surgery ☐ Pacemaker ☐ hysterectomy

☐ Tonsillectomy ☐ Vasectomy ☐ Cosmetic surgery ☐ Elective surgery:_____ ☐ Other:_____

Have you had any of these treatments past or present?:

Past	Present		Past	Present		Past	Present		Past	Present	
☐	☐	Acupuncture	☐	☐	Chiropractic care	☐	☐	Heel lifts/Orthotics	☐	☐	Hormone replacement
☐	☐	Blood transfusions	☐	☐	Steroid Injections	☐	☐	Herbs	☐	☐	Massage therapy
☐	☐	Chemotherapy	☐	☐	Dialysis	☐	☐	Homeopathy	☐	☐	Physical therapy
☐	☐	Medications:_____				☐	☐	Nutritional supplements:_____			

Family health history (heart disease, cancer, diabetes, arthritis, etc.):_____

How does your current condition interfere with your life and ability to function?:

	No Affect	Mild Affect	Moderate Affect	Severe Affect		No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	☐	☐	☐	☐	Grocery shopping	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐	Household chores	☐	☐	☐	☐
Standing	☐	☐	☐	☐	Lifting objects	☐	☐	☐	☐
Walking	☐	☐	☐	☐	Reaching overhead	☐	☐	☐	☐
Lying down	☐	☐	☐	☐	Showering or bathing	☐	☐	☐	☐
Bending over	☐	☐	☐	☐	Dressing myself	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐	Love life	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐	Getting to sleep	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐	Staying asleep	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐	Concentrating	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐	Exercising	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐	Yard work	☐	☐	☐	☐

REASON FOR VISIT

Reason for this visit: ☐ *Accident or injury* ☐ *Worsening long term problem* ☐ *Interest in wellness* ☐ *Other:* _____

*Please describe your symptoms:*_____

*Date of onset:*_____ *Have you had this or similar conditions in the past?:* ☐ *Yes* ☐ *No*

Level of current symptoms? (please circle): *0 1 2 3 4 5 6 7 8 9 10* ☐ *Constant* ☐ *Comes and Goes*
Absent *Uncomfortable* *Agonizing*

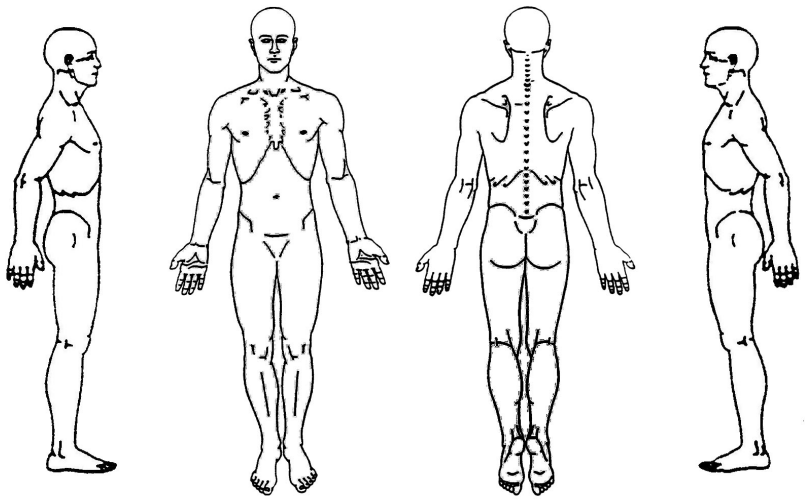
Does the current condition interfere with: ☐ *Work* ☐ *Sleep* ☐ *Daily routine* ☐ *Recreational activities* ☐ *Household responsibility*

Does pain/numbness/tingling radiate to other areas, i.e. down the arms or legs? ☐ *Yes* ☐ *No* *Where?:*_____

*What makes the symptoms better?:*_____ *Worse?:*_____

Have you previously been treated for this condition?: ☐ *Yes* ☐ *No* *Have you ever consulted a chiropractor in the past?:* ☐ *Yes* ☐ *No*

Please mark the area(s) of injury or discomfort using the letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing. **A**=Ache **B**=Burning **N**=Numbness **P**=Pins & Needles **S**=Stabbing **O**=Other



Right Side Front Back Left Side

Doctor's Notes:

_____

_____

_____

_____

_____

continued on back

Please read and sign:

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understating between provider and patient

I instruct the chiropractor to deliver the care that, in his professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation.

I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health Information to me as an extension of my care in this office.

I acknowledge that any insurance I may have is an agreement between the insurer and me and that I am responsible for the payment of any covered or non-covered services I receive.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature:_____ Date:_____

☐ Adult patient ☐ Parent or guardian ☐ Spouse *(mm/dd/yyyy)*