# New Patient Health History Form

**Boca Health & Wellness Center**
3350 N.W. Boca Raton Blvd. Ste. A-24, Boca Raton, FL 33431
(561) 447-2228

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

## Mailing address

Address | City | State | Zip

Telephone (Work) | (home) | Referred By

Age | Birth Date | Social Security # | Number of Children

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 _____

Spouse's or guardian's signature _____ Date _____

## Medical History

Have you been treated for any conditions in the last year? ◯ No ◯ Yes

If yes, please describe

Date of last physical exam  Is there a chance that 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)I

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.)**

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

What activities aggravate your symptoms?

| Habits | None | Light | Moderate | Heavy |
|---|---|---|---|---|
| Alcohol | ◯ | ◯ | ◯ | ◯ |
| Coffee | ◯ | ◯ | ◯ | ◯ |
| Tobacco | ◯ | ◯ | ◯ | ◯ |
| Drugs | ◯ | ◯ | ◯ | ◯ |
| Exercise | ◯ | ◯ | ◯ | ◯ |
| Sleep | ◯ | ◯ | ◯ | ◯ |
| Appetite | ◯ | ◯ | ◯ | ◯ |
| Soft Drinks | ◯ | ◯ | ◯ | ◯ |
| Water | ◯ | ◯ | ◯ | ◯ |
| Salty Foods | ◯ | ◯ | ◯ | ◯ |
| Sugary Foods | ◯ | ◯ | ◯ | ◯ |
| Artificial Sweeteners | ◯ | ◯ | ◯ | ◯ |

**Have you ever suffered from:**

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

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

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