

Houston Spine Wellness, PC

2219 Sawdust Road, #803 Woodlands, Texas 77380
Phone: 713-907-1731 1chiroinwoodlands.com * Fax: 713-583-1413



New Patient Health History Form

Please PRINT Clearly

YOUR INFORMATION

Last Name	First Name	Middle Initial	Nickname/AKA	
Date of Birth	Social Security Number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Life Partner <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other		Language <input type="checkbox"/> English	Other: _____	
Occupation	Employer Name and Address			
Home Address	Apt #	City	State	Zip Code
Home Phone	Work Phone	Cell Phone		
Email Address				

WHAT BRINGS YOU IN TODAY?

Date of onset _____ Is this from an automobile accident? YES NO
PLEASE DESCRIBE INJURY: _____

Date of injury/ symptoms appeared? _____
Have you ever had this same condition? YES NO If yes, when? _____
Please list any other providers you have seen for this injury/ condition? _____
Have you ever been under chiropractic care in the past? YES NO If yes, please describe: _____
Is this condition: Job Related / Auto Related / Home Injury / Fall / Other _____

***** If condition is related to an Auto Accident or Job Injury and will be paid for by Worker's Comp or Auto Insurance, please inform the receptionist immediately in order for you to fill out the appropriate paper work!! *****

INSURANCE (GUARANTOR) INFORMATION

Do you have health insurance? YES NO If yes, company name _____
Insurance Address _____
Group# _____ Member# _____
If Automobile accident, provide contact person and CLAIM# _____

EMERGENCY INFORMATION

Last Name	First Name	Relationship to Patient		
Address	Apt #	City	State	Zip Code
Home Phone	Work Phone	Other Phone	<input type="checkbox"/> Cell	

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YOUR MEDICAL HISTORY

Have you been treated for any conditions in the past year? YES NO If yes, please describe _____

Date of last physical exam _____ Is there a chance you might be pregnant? YES NO

Have you had X-Rays taken? YES NO If yes, when and where? _____

What medications are you currently taking, for what condition, and dosage? _____

What vitamins/ minerals/ herbs/ supplements are you currently taking, for what conditions, and dosage? _____

Have you ever:	Yes	No	Briefly explain
Broken Bones?	◇	◇	
Been hospitalized?	◇	◇	
Been in an automobile accident?	◇	◇	
Had sprains/ strains?	◇	◇	
Been struck unconscious?	◇	◇	
Had any surgery?	◇	◇	

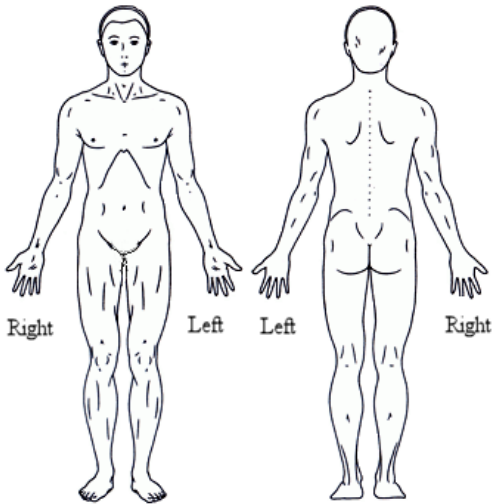
FAMILY HISTORY Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER	MOTHER	SPOUSE	SIBLING(S)		CHILDREN	
	Age []	Age []	Age []	Age []	Age []	Age []	Age []
Arthritis							
Allergies, Asthma, or Hay Fever							
Diabetes							
Bursitis							
Cancer							
Back Trouble							
Disc Problems							
Pinched Nerve							
Scoliosis							
Epilepsy							
Headaches/ Migraines							
Heart Disease/ High Blood Pressure							
Kidney/ Liver Trouble							
Anxiety/ Depression/ Nervousness							
Neuritis/ Neuralgia							
Other:							

YOUR MEDICAL HISTORY (CONTINUED)

Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10



Using the symbols below, mark on the pictures where you feel pain.

- Numbness N
- Dull Ache A
- Burning B
- Sharp/Stabbing S
- Pins, Needles P
- Other _____ O

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? Y/N

Is this condition interfering with

Work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition progressively getting worse? Y/ N

Do you wear orthotics? Y/ N

Do changes in weather affect your symptoms? Y / N

HABITS	NONE	LIGHT	MODERATE	HEAVY (AMT)
Alcohol				
Coffee/ Caffeine				
Tobacco				
Recreational Drugs				
Exercise				
Sleep				
Appetite				
Salty Foods				
Sugary Foods				
Soda/ Soft Drinks				
Artificial Sweeteners				
Water				

Please mark any of the following conditions or symptoms that you have now or have experienced:

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in Hands or Arms | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Hands or Arms | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pain in Legs or Feet | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Numbness in Legs or Feet | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Depression | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Sinus | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Heartburn/Reflux |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Allergies | <input type="checkbox"/> Loss of Smell or Taste |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Jaw/TMJ Problems | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Menopause |

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YOUR GOALS AND EXPECTATIONS (circle all that apply)

My goal for consulting with the doctor today:

- | | | |
|--|---|--|
| <input type="checkbox"/> Temporary Relief from pain and symptoms | <input type="checkbox"/> Lasting chiropractic wellness care | <input type="checkbox"/> nutritional/ herbal support |
| <input type="checkbox"/> Diet/ Lifestyle improvement | <input type="checkbox"/> Weight management | <input type="checkbox"/> Detox and purification |
| <input type="checkbox"/> Relief from allergies | <input type="checkbox"/> Other (describe) | <input type="checkbox"/> Other (describe) |

Let doctor recommend best type of care

I HEREBY ACKNOWLEDGE AND ATTEST TO THE INFORMATION OF THIS FORM AS BEING ACCURATE, COMPLETE, AND UNDEVIATING. THROUGH MY SIGNATURE BELOW I HEREBY GIVE PERMISSION TO THE DOCTOR(S) TO PERFORM THE PROCEDURES WHICH ARE DETERMINED TO BE NECESSARY IN THE DIAGNOSIS AND TREATMENT OF MY CONDITION.

Patient Name (print) _____

Patient Signature _____ Date _____

Parent Signature if applicable _____ Date _____

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Missed Appointment Policy

Here at Houston Spine Wellness, P.C. we encourage you (patient) to keep appointments designated by the doctor. We understand unforeseen events can occur, so we request that you (patient) call at least 24 hours in advance to cancel or reschedule appointments, allowing appointment availability for other patients requesting to see the doctor. A failed appointment or failure to contact our office at least 24 hours in advance will result in a \$25 failed appointment fee.

I _____ have read and understand the missed appointment policy.

Patient Signature

Date