# Millis Family Chiropractic
# HEALTH HISTORY FORM

Date ______________

Name: ____________________________________________________________________

Address: __________________________________________________________________

City: ____________________________ State: _______________ Zip: _________________

Home Phone: ______-______-_______Work Phone: ______-______-_______ Cell Phone: _____-______-_______

Email Address: _____________________________ Occupation: _________________________________________

Date of Birth ________________________ Age ______ Gender: F M Social Security #: _______-______-_______

Marital Status: S M D W L/W Name of Spouse ____________________________________________________

Name and ages of Children ___________________________________________________________________________

Who referred you to our office? ________________________________________________________________________

For the following categories, please circle what is true for you:

List any **Allergies** (circle all that apply):

Animals Aspirin Bees Chocolate Dairy Dust Eggs Latex Molds Penicillin Ragweed/Pollen

Rubber Seasonal Allergies Shellfish Soaps Wheat Other: _______________________________________

List any **Surgeries** (circle all that apply and include year surgery was performed):

Back Brain Elbow Foot Hip Knee Neck Neurological Shoulder Wrist Other: ____________________

List **ALL** **Past Medical History** conditions (circle all that apply):

Ankle Pain Arm Pain Arthritis Asthma Back Pain Broken Bones Cancer Chest Pain Depression

Diabetes Dizziness Elbow Pain Epilepsy Eye/Vision Problems Fainting Fatigue Foot Pain

Genetic Spinal Condition Hand Pain Headaches Hearing Problems Hepatitis High Blood Pressure

Hip Pain HIV Jaw Pain Joint Stiffness Knee Pain Leg Pain Menstrual Problems Mid-Back Pain

Minor Heart Problem Multiple Sclerosis Neck Pain Neurological Problems Pacemaker Parkinson's

Polio Prostate Problems Shoulder Pain Significant Weight Change Spinal Cord Injury Sprain/Strain

Stroke/Heart Attack Other: __________________________________________________________________________

List Type of **Medications** you are taking (circle all that apply):

Anxiety Muscle Relaxors Pain Killers Insulin Birth control Cardiovascular Allergy Seizure

Other: _____________________________________________________________________________________

List your **Family History** (circle all that apply):

Arthritis Asthma Back Pain Cancer Depression Diabetes Epilepsy Genetic Spinal Condition Stroke/Heart Attack

High Blood Pressure Heart Problems Multiple Sclerosis Neurological Problems Parkinson's Prostate Problems

Other: _____________________________________________________________________________________

Have you had any auto or other accidents? ____ No ____ Yes When? _________________________________

Describe: __________________________________________________________________________________

Date of last physical examination: _________________ Do you smoke? ___ No ___ Yes

Do you drink alcohol? ___ No ___ Yes - how many per day? _________________

Do you drink caffeine? ___ No ___ Yes - how many per day? _________________

Do you exercise? ___ No ___ Yes (what forms and how often): ___________________________________________________

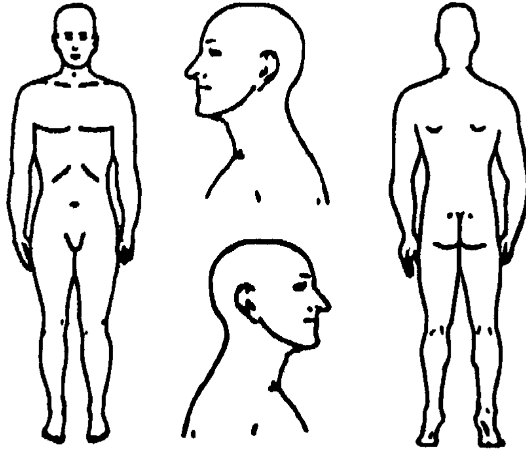
Have you ever had chiropractic care? ___ No ___ Yes When? ____________________ Why? ______________________

Where? _________________________________ Were X-rays taken? Yes No When was your last adjustment? _________

## Reason for this visit

Main reason for consulting the office: ___ Become pain free ___ Explanation of my condition
___ Learn how to care for my condition ___ Reduce Symptoms ___ Resume normal activity level

*PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW*



What is your major complaint? ________________________________________ Date problem began? _________________

How did this problem begin (falling, lifting, etc.)? ____________________________________________________________

How is your condition changing? ____ GETTING BETTER ____ GETTING WORSE ____ NOT CHANGING

Have you had this condition in the past? ____ NO ____ YES

How often do you experience symptoms? (circle):

Constantly (76-100% of the day) Frequently (51-75% of the day)
Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms (circle all that apply): Sharp Dull Numb Burning Shooting Tingling
Radiating Pain Tightness Stabbing Throbbing Other: _____________________________________

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain):

1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?
(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? Please describe:

______________________________________________________________________________________________

What makes your pain better (ice, heat, massage, etc)? ______________________________________________________

Secondary complaint? _____________________________________________ Date problem began? _______________

How did this problem begin (falling, lifting, etc.)? __________________________________________________________

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? ____ No ____ Yes

How often do you experience symptoms? (circle):

Constantly (76-100% of the day) Frequently (51-75% of the day)
Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms (circle all that apply): Sharp Dull Numb Burning Shooting Tingling
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How do your symptoms affect your ability to perform daily activities such as working or driving?
(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? Please describe:

_________________________________________________________________________________________________

What makes your pain better (ice, heat, massage, etc)? _____________________________________________________

Anything else you like to share? ___________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

## *FINANCIAL INFORMATION* and *AUTHORIZATION*

Payment in full is expected on all FIRST VISIT services.
All other fees are to be paid at time of service unless other arrangements have been made.
Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit or Debit
Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide in our office.
Complete the following information
❑ Health Ins ❑ Auto Accident ❑ Medicare ❑ Worker's Compensation
Name of Insurance Co: ____________________________________________________________________
Insured's Name (if different from person receiving care): _____________________________________________
ID# ___________________________________________ Policy# __________________________________________
Group Name & # __________________________________________________________________________

*The information I have provided, on this case history form, is true and accurate, to the best of my knowledge.*
*I give Dr. Stephen Stern permission to render care to me today.*
*This initial visit includes a health history/consultation, chiropractic exam/evaluation,*
*and any initial care that is determined to be clinically necessary, and mutually agreed upon.*
*I understand that I am responsible for any balance due that is not paid by Insurance Company.*

*Patient (Print Name)* ______________________________________________________________

*Signature* _________________________________________________________________ *Today's Date*______________

*Signature of Parent (for minor)* ____________________________________________