

**Health History Form**



Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Gender: Male/Female  
 SSN#: \_\_\_\_\_ Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

Appointment reminders via text? YES / NO Occupation: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_ Single/Divorced/Widowed/Married (Spouse's Name: \_\_\_\_\_)

#of Children, Names, Ages & Gender \_\_\_\_\_

**Main Health Concern History**

Health Concerns: In order of Severity	Rate of Severity 1=Mild 10= Unbearable	How long have you had this?	Did this start with an injury?	Have you had this before?	Is this constant or comes/goes?
1.					
2.					
3.					
4.					

- Please check all that apply when describing the pain?  Sharp  Soreness  Throbbing  Tingling  Dull  Stiffness  Spasm  Burning  Ache  Weakness  Numbness  Shooting
- Does the pain travel anywhere else?  YES or  NO Describe: \_\_\_\_\_
- How often is this present?  Constant (81-100%)  Frequent (51-80%)  Occasional (26-50%) Intermittent (25% or less)
- Since it started, has the pain gotten better, worse or stayed the same? \_\_\_\_\_
- What makes your health concern worse?  
 5.1.  Nothing  Walking  Standing  Sitting  Exercise (moving)  Lying Down  Other
- Have you seen anyone for this health concern? (Chiropractor, Medical Doctor, etc.) If so, who?  
 \_\_\_\_\_
- Please list all medications, including vitamins/supplements, you are taking and for what?  
 \_\_\_\_\_
- Please list any broken bones, surgeries, or hospitalizations you have had and when:  
 \_\_\_\_\_
- Please list any auto accidents or major slips/falls/traumas you have been involved in:  
 \_\_\_\_\_
- Spinal health is especially important during pregnancy; **any chance** that you are pregnant? **YES or NO**

**PAST HISTORY**

Have you suffered with any of this or a similar problem in the past?  No  Yes **If yes**, how many times? \_\_\_\_\_ When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_

Other forms of treatment tried:  No  Yes **If yes**, please state **what** type of treatment: \_\_\_\_\_, and who provided it: \_\_\_\_\_ **How long ago?** \_\_\_\_\_ What were the results.  Favorable  Unfavorable → please explain. \_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:  
 \_\_\_\_\_

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have or **N** for **Never** have had:

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability \_\_\_ Cancer \_\_\_ Heart Attack \_\_\_ Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular \_\_\_ Other\_\_\_\_\_

**SOCIAL HISTORY**

- 1. **Smoking:**  cigars  pipe  cigarettes How often?  Daily  Weekends  Occasionally  Never
- 2. **Alcoholic Beverage:** consumption occurs  Daily  Weekends  Occasionally  Never
- 3. **Recreational Drug use:**  Daily  Weekends  Occasionally  Never
- 4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect? (See ADL form)

**FAMILY HISTORY:**

- 1. Does anyone in your family suffer with the same condition(s)?  No  Yes **If yes whom:**  grandmother  grandfather  mother  father  sister(s)  brother(s)  son(s)  daughter(s)  
Have they ever been treated for their condition?  No  Yes  I don't know
- 2. **Any other hereditary conditions the doctor should be aware of?**  No  Yes:

**On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: \_\_\_\_\_**

*This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely. IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.*

\_\_\_\_\_  
Printed Name Signature Date  
Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Minor \_\_\_\_\_

**Insurance Release of Authorization/Assignment of Benefits**

I hereby authorize payment to be made directly to **CTC Chiropractic** for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to **CTC Chiropractic** for any and all services I receive at this office.

Insurance Verification Form

NAME OF PRIMARY INSURANCE CARRIER: \_\_\_\_\_ NAME OF SECONDARY INSURANCE CARRIER: \_\_\_\_\_  
Name of insured \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_ Insured Social Security: \_\_\_\_\_

**FEES: We have a zero balance policy. Payment for services is due at the time of services rendered. Payment options include; cash, check, debit/credit card, Amex, and HSA/HRA cards. Returned checks will be billed to the patient for the amount of the check as well as a returned check fee of \$15.00. We reserve the right to charge \$35 late fee for all late payments.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_



## QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name \_\_\_\_\_

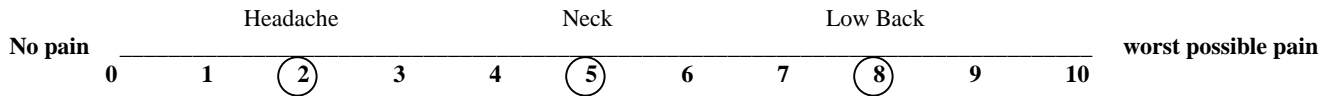
Date \_\_\_\_\_

**Please read carefully:**

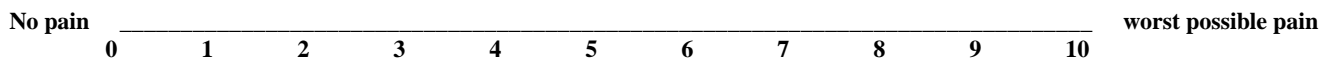
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

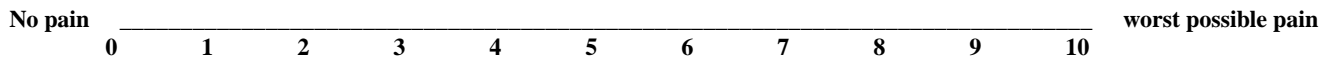
**Example:**



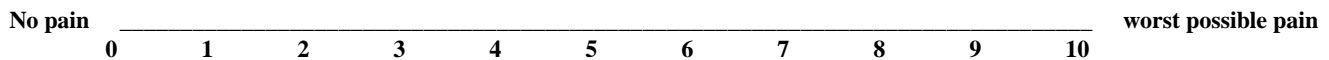
**1 – What is your pain RIGHT NOW?**



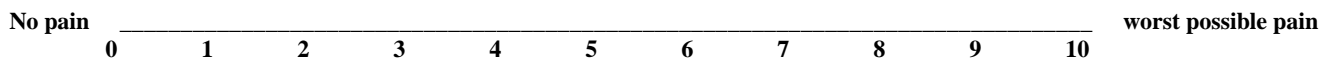
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**



**OTHER COMMENTS:**

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Examiner \_\_\_\_\_

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.