# NEW PATIENT HISTORY

Patient Name____________________________ Date____________________

Address________________________________ City__________________________ State________ ZIP_____________

Home Phone______________________ Work phone_____________________ Cell phone_______________________

E-Mail Address________________________________

Sex: M F Marital Status: M S D W Date of Birth______________ Age__________

Social Security #________________________________

Occupation:___________________________________ Employer:_____________________________________

Referred by:_____________________________________

Have you ever received chiropractic care? Y N If yes, when?________________________________________
Name of most recent chiropractor?________________________________________________

**1. Reason for seeking chiropractic care?**

Primary reason:_____________________________________________________________________________________

Secondary Reason:__________________________________________________________________________________

**2. Previous interventions, treatments, medications, surgeries or care you've sought for your complaint(s)?**
_____________________________________________________________________________________________________
_____________________________________________________________________________________________

**3. Past Health History:**

**A. Please circle if you have a history of any of the following:**

Aids Allergies Anemia Arthritis Asthma Back Pain Bladder trouble Bone Fracture

Cancer Chest pain Concussions Constipations convulsions depressions diarrhea Dislocated joints

Epilepsy Fibromyalgia Headaches Heart trouble Hepatitis Herniated disc High blood pressure

High cholesterol HIV Kidney disorder Loss of bowel control Lung disease Menstrual cramps

Migraine headaches Multiple Sclerosis Muscular Dystrophy Neck Pain Nervousness Numbness

Osteoporosis Parkinson's Polio Poor circulation Reproductive disorders Rheumatic fever

Rheumatoid arthritis Scarlet fever Scoliosis Serious injury Sinus troubles Stroke Thyroid problems

Tuberculosis Tumors/growths ulcers Venereal disease OTHER_________________________ None of the above

IF YOU HAVE OR HAVE HAD ANY OF THE ABOVE, PLEASE EXPLAIN:_________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________

**B. Previous Injury or Trauma**

______________________________________________________________________________

**Have you broken any bones? – Which?**

______________________________________________________________________________

**C. Allergies:**

______________________________________________________________________________

**D. Medications:**

**Medication** **Reason for taking:**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**E. Surgeries**

**Date** **Type of surgery** **Outcome**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**FEMALES- PREGNANT: Y N** **If yes, Due date:_____________________**

**F. Family health history:**

Does any of your immediate family have or have had the following:

Cancer: (type)______________ (Whom)_________________ Clotting disorder: (Whom)_____________________

Dimentia/Alzheimers: (Whom)_____________________ Diabetes: (Type)________ Whom:________________________

Gastrointestinal (Whom)__________________ Heart disease: Type_______________ Whom:________________________

Hypertension: (Whom)________________________ Kidney Disease: (Whom)___________________________________

Lung Disease: (Whom)________________________ Psychological disorder: (Whom)______________________________

Septicemia: (Whom)__________________________ Stroke: (Whom)____________________________________________

OTHER FAMILY HISTORY:______________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

**G. Social and Occupational History:**

Job Description:______________________________________________________________________

Work Schedule:_______________________________________________________________________

Recreational Activities:_________________________________________________________________

Lifestyle: (Hobbies, Level of exercise, Alcohol, Tobacco, Drug use):_____________________________________

________________________________________________________________________________

**H. IS THERE ANYTHING ELSE IN YOUR PAST MEDICAL HISTORY THAT YOU FEEL IS IMPORTANT FOR DR. MOSS TO KNOW:**

________________________________________________________________________________

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Moss Chiropractic to provide me with chiropractic and/or acupuncture care in accordance with Idaho State law and statutes. If any insurance will be billed, I authorize payment of benefits to Daryl A. Moss, D.C. / Moss Chiropractic, P.A. for services performed.

Patient/Guardian Signature:__________________________________________________________ Date:_________________