PARKWOOD
FAMILY CHIROPRACTIC

NEW PATIENT HEALTH HISTORY

8380 Warren Parkway
Suite 601
Frisco, TX 75034
972.437.8040

PATIENT INFORMATION

Name (First, Middle, Last) ______________________ Preferred Name______________

Address ______________________

City, State, Zip Code ______________________

M F Age ______ Birthday (mm/dd/yy) __________ Social ______________

Marital Status S M W D (circle one) Appointment Date ______________

Email Address ______________________

Cell Phone ______________ Home Phone ______________

Business Phone ______________ Other Phone ______________

Preferred Method(s) of Contact ______________________

Occupation ______________________

Employer ______________________

Spouse's Name ______________ Occupation ______________

Children (Names & Ages) ______________________

Referred to PFC By ______________________

IN CASE OF EMERGENCY PLEASE CONTACT:

Name (First & Last) ______________ Relationship to Patient ______________

Cell Phone ______________ Other Phone ______________

INSURANCE INFORMATION

Primary Insurance ______________________

Personal ID No. ______________ Group No. ______________

Customer Service # ______________ Relationship to Primary______________

Primary Subscriber ______________ Birthday (mm/dd/yy) ______________

Do you have an HSA or FSA? (Health Savings Account/Flexible Spending Account)______________

Do you have an HRA? (Health Reimbursement Account) Used $ ________ Remaining $ ________

Secondary Insurance ______________________

Personal ID No. ______________ Group No. ______________

Customer Service # ______________ Relationship to Primary______________

Primary Subscriber ______________ Birthday (mm/dd/yy) ______________

ASSIGNMENT AND RELEASE:
I, the undersigned, certify that I (or my dependant) have insurance coverage with ______________ and assign directly to Benjamin Wagley, D.C. all insurance benefits payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature ______________________ Date ______________

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HEALTH GOALS

What are your top 3 health goals (related -*or*- unrelated to primary complaint):

1.______________________________

2.______________________________

3.______________________________

What are your favorite activities or hobbies that could be affected by your health?

____

What are some activities or hobbies that you are currently *unable* to do because of your health that you would like to be able to do in the future?

____

HEALTH INTERESTS

How interested are you in the following areas:

Nutrition	Not Interested	Somewhat Interested	Very Interested	Extremely Interested
Supplements	Not Interested	Somewhat Interested	Very Interested	Extremely Interested
Healthy Lifestyle	Not Interested	Somewhat Interested	Very Interested	Extremely Interested
Weight Loss	Not Interested	Somewhat Interested	Very Interested	Extremely Interested
Disease Prevention	Not Interested	Somewhat Interested	Very Interested	Extremely Interested
Massage	Not Interested	Somewhat Interested	Very Interested	Extremely Interested

PAST CHIROPRACTIC EXPERIENCE

When did you last see a chiropractor? (Date or Date Range)______________________________

Dr. Name / Practice ______________________________

What was your primary reason for seeing the chiropractor?______________________________

Were you offered a wellness care plan to improve your health?______________________________

Were you able to follow the doctor's recommendations?______________________________

Why are you changing chiropractors?______________________________

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PRIMARY HEALTH CONCERN

What is the PRIMARY reason for your visit? ______________________

How long have you suffered with this? ______________________

How did this condition begin? ______________________

If symptoms are present they feel like: (circle all that apply)

Aching Sharp Dull Burning Shooting Numbness

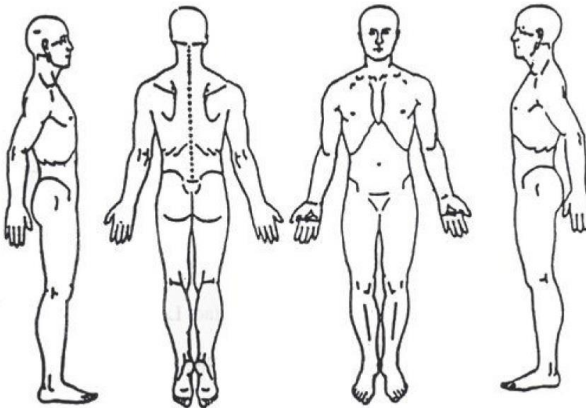
Tingling Throbbing Cramping Stiffness Weakness

Are symptoms worse at certain times of day? ______________________

What percentage of the day do you have symptoms? ______________________

What makes symptoms worse? ______________________

What makes symptoms better? ______________________



Please circle areas where symptoms are present.

Next to each circle, please rate the symptom on a scale of 1-10
(10 = most severe, 1 = least severe)

OTHER HEALTH CONCERNS

Please list any other health concerns or pain that you are currently experiencing:

____

____

____

____

____

____

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NEW PATIENT HEALTH HISTORY

CHILDHOOD GROWTH/HISTORY		COMMENTS
Breast fed	Y N	
Vaccinated	Y N	
Have childhood illnesses	Y N	
Ear infections	Y N	
Colic	Y N	
Asthma	Y N	
Antibiotics administered	Y N	
Drugs (Rx, OTC, Recreational)	Y N	
Surgeries	Y N	
Hospitalizations for illness	Y N	
Youth sports or physical activities	Y N	
Injuries during sports	Y N	
Auto or sport vehicle accidents	Y N	
Any other traumas	Y N	
Any bones broken	Y N	

CURRENT/PAST HEALTH HISTORY		COMMENTS
Dental/gum problems	Y N	
Eye/vision problems	Y N	
Hearing problems	Y N	
Headaches	Y N	
Tinnitus/Ringing in the ears	Y N	
Depression	Y N	
Mental Illness	Y N	
TMJ/Locking of the jaw	Y N	
Broken Bones	Y N	
Torn Ligaments	Y N	
Heartburn/reflux	Y N	
High/low blood pressure	Y N	
High cholesterol	Y N	
Diabetes – Type 1 or 2	Y N	
Hypoglycemia	Y N	

CURRENT HEALTH HABITS		How much/often
Drink alcohol	Y N Past	
Drink coffee	Y N Past	
Drink water	Y N Past	
Daily sweets	Y N Past	
Sugar substitutes	Y N Past	
Dieting or cleansing	Y N Past	
Smoke cigarettes	Y N Past	
Chew tobacco	Y N Past	
Recreational drug use	Y N Past	
OTC drug use	Y N Past	
Prescription drug use	Y N Past	
Exercise regularly	Y N Past	
Sleep irregularity	Y N Past	
Occupational stress	Y N Past	
Relationship stress	Y N Past	
Drive long distances	Y N Past	
Wear orthotic/shoe lifts	Y N Past	
Usual sleeping position	Side Stomach	Back

CURRENT/PAST HEALTH HISTORY (cont.)		COMMENTS
Asthma	Y N	
Allergies – Seasonal	Y N	
Allergies – Food	Y N	
Respiratory infections	Y N	
Sinus infections	Y N	
Heart Attack	Y N	
Stroke	Y N	
Mono or other serious virus	Y N	
Cold hands/feet	Y N	
Weight loss/gain	Y N	
Hyper/Hypothyroidism	Y N	
Arthritis	Y N	
Colitis / Chron's / IBS	Y N	
Frequent constipation	Y N	
Frequent diarrhea	Y N	
Sleep problems	Y N	
Cancer	Y N	
Surgeries	Y N	

MEDICATIONS	ALLERGIES	VITAMINS/HERBS

FOR WOMEN ONLY		COMMENTS
Are you currently pregnant	Y N	
Number of pregnancies		
Number of live births		
Fertility Issues	Y N	
Menopause	Y N	

EXERCISE				
None	Occasional	Moderate	Daily	Heavy

WORK ACTIVITY				
Sitting	Standing	Twisting	Light Labor	Heavy Labor

CURRENT EATING HABITS		COMMENTS
Vegetarian	Y N	
Sugar intake	Little/None	Moderate High
Do you skip meals	Y N	

ADDITIONAL NOTES REGARDING HISTORY OR HEALTH

I hereby certify that the statements and answers given are accurate to the best of my knowledge, and I understand that it is my responsibility to inform this office of any changes in my health.

____________________ Patient Printed Name (full name)

____________________ Patient Signature

____________________ Date (mm/dd/yy)