Health History Information

Last Name: First Name:	Middle:	❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Widow
Email:		Birth date:	Age:	Sex:
Address:	City:	State:		
ZIP Code:	Social Security No.:	Home Phone:		
Occupation:	Employer	Work Phone:	Cell Phone:	
Please let us know who referred you here:				

Medical Care Information

Do You Have a Family Medical Doctor? ❑ No ❑ Yes, Name of Doctor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Prior Illness:		

Please list any medication allergies:			
Have you had surgeries in the last 5 years: ❑ Yes ❑ No	If yes, Last Surgery Date:		
Reason for Surgery:			

Social History

Alcohol? ❑ No ❑ Yes Drinks per week?	Cigarettes? ❑ No ❑ Yes Packs per day?	Caffeine? ❑ No ❑ Yes Drinks per day?	Exercise? ❑ No ❑ Yes Hours per week: (Circle One) Light / Moderate / Strenuous
Daily Water Consumption:	Hobbies and Recreational Activities:		

Smoking

❑ Current every day smoker ❑ Current some day smoker ❑ Former smoker ❑ Never ❑ _____ Date Started

Have you ever been treated for substance abuse or used illegal drugs? ❑ No ❑ Yes ❑ _____ Date Stopped

Medications + Supplements **(Use Backside if Needed)**

Medication Name	Dose	Form	Route	Frequency	Date Started
E.G. Zyrtec	10 mg	Tablet	By mouth	once per day	10/24/2008

Race: ☐ White ☐ African American ☐ Asian ☐ Am Indian or AK Native ☐ Native Hawaiian or other Pacific Islander ☐ Decline

Preferred Contact: ☐ Phone ☐ Email ☐ Text ☐ Fax ☐ Postal Mail ☐ Other: _____

PLEASE MARK HERE IF YOU HAVE **MEDICARE** AS YOUR PRIMARY INSURANCE _____

Is this due to: ☐ Automobile Injury ☐ Work-Related Injury

Payment will be required at the time services are rendered, unless other arrangements are made in advance.

AUTHORIZATION AND RELEASE: I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, research, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand there will be a fee added to overdue accounts.

Signature: _____ Date: _____

Parent/Guardian (If under 18 yrs old): _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Valley Chiropractic Associates