PRECISION
CHIROPRACTIC

New Adult Practice Member History Form

To our new practice members: Welcome to Precision Chiropractic! To help us establish you with our practice, please provide us with your health history. If you have any questions, please let us know. We look forward to working with you to achieve your health goals.

First Name____________________Middle_____________Last____________________Nickname ____________

Birthdate__________Age ___ Gender [M F] Marital Status[S M W D P]Spouse/SO name ____________

Address___________________________________City/State___________________Zip ____________________

Best Phone_____________________[mobile work home] Other Phone__________________[mobile work home]

Mobile Phone Provider________________________Email ____
(information only used for our text message appointment reminders) (only used in-house, never given out to 3rd parties)

How did you find us?___________________________Occupation/Employer_______________________________

Emergency Contact Name___________________Phone________________________Relationship____________

Please describe what is going on:

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____
____
____
____

What result would you like to achieve:

____
____
____

In your opinion, how would you rate your overall health?

poor 1 2 3 4 5 6 7 8 9 10 great

Are you on any medication? ☐ Yes (list below) ☐ No

____
____
____

Have you been seen by another doctor in the last year?
☐ Yes (describe below) ☐ No

____
____

Personal Health History (please check the box of any that are relevant to your history)

☐ Cancer	☐ High Blood Pressure	☐ Head Trauma	☐ Car Accidents	☐ Facial Pain	☐ Smoker (daily/social)
☐ MS	☐ Allergies	☐ Concussion	☐ Broken Bones	☐ Neck Pain	☐ Alcohol (daily/social)
☐ Diabetes	☐ Sleeping Trouble	☐ Headaches	☐ Surgery	☐ Mid-Back Pain	☐ Caffeine(daily/social)
☐ Parkinson's	☐ Fatigue	☐ Migraines	☐ Joint Replacement	☐ Low Back Pain	☐ Poor Diet
☐ Tuberculosis	☐ Digestive Disorder	☐ Depression	☐ Hysterectomy	☐ Arm Pain	☐ No Exercise
☐ Seizures	☐ Sinus Trouble	☐ Anxiety	☐ Hearing aids	☐ Hand Pain	☐ Artificial Sweeteners
☐ Heart Trouble	☐ Ear Trouble/Ringing	☐ Dizzy/Balance Issues	☐ Dentures	☐ Leg/Foot Pain	☐ Yearly Flu Shot
☐ Alzheimer's	☐ Asthma	☐ Numbness/Tingling	☐ Arthritis	☐ Other___________	☐ Stress

For Women Only: Are you Pregnant? ☐ Yes ☐ No ☐ Unsure Date of Last Period:__________ Menstrual Cramps? ☐ Yes ☐ No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend of terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Vital Force Clinic and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Gaurdian's) Signature Date