

Family Chiropractic Clinic/1<sup>st</sup> Care Medical Testing  
5790 W. Hwy. 287, Midlothian, TX 76065  
(972)723-9411

**CONFIDENTIAL HEALTH HISTORY**

All information provided is strictly confidential, however, occasionally an insurance company will request such information. If you have information to share with the doctor that is sensitive, relay it to him verbally and it will not be included in your chart.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

SS # \_\_\_\_\_ E-Mail \_\_\_\_\_ Pager: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status S M W D # of Children \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Position: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Spouse/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Spouse's Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Position: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

How did you hear about us: (newspaper, yellow pages, friend, etc.) \_\_\_\_\_

Have you been treated by a Chiropractor before? \_\_\_\_\_ If yes, who? \_\_\_\_\_

Date of last visit: \_\_\_\_\_

List any falls, trauma, accidents you have had. \_\_\_\_\_

\_\_\_\_\_

# PATIENT HEALTH HISTORY

Do you smoke? \_\_\_\_\_ How many cigarettes each day? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How much alcohol each day? \_\_\_\_\_ or week? \_\_\_\_\_

Do you partake of illicit drugs? \_\_\_\_\_ How often? \_\_\_\_\_ What kind? \_\_\_\_\_

Have you ever been diagnosed with:

High Blood Pressure \_\_\_\_\_ Age \_\_\_\_\_ How treated? \_\_\_\_\_

Heart Trouble \_\_\_\_\_ If yes, what type \_\_\_\_\_ Age \_\_\_\_\_

Respiratory problems? \_\_\_\_\_ If yes, what type \_\_\_\_\_ Age \_\_\_\_\_

Please list any surgeries you have had and the year it was performed. \_\_\_\_\_  
\_\_\_\_\_

Please list any serious illnesses or injuries and the year it occurred. \_\_\_\_\_  
\_\_\_\_\_

Are you pregnant at this time? \_\_\_\_\_ When are you due to deliver? \_\_\_\_\_

What is the name of your OB/GYN doctor? \_\_\_\_\_

City: \_\_\_\_\_ Phone: \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

City: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any allergies? \_\_\_\_\_ At what age were you diagnosed? \_\_\_\_\_

What allergens affect you? \_\_\_\_\_

Please list any medications you are allergic to. \_\_\_\_\_  
\_\_\_\_\_

Please list any medications taken daily, the dosage and frequency. \_\_\_\_\_  
\_\_\_\_\_

Are you taking any vitamins or supplements, if yes, please list them. \_\_\_\_\_  
\_\_\_\_\_

Do you exercise daily? \_\_\_\_\_ What type? \_\_\_\_\_ How long? \_\_\_\_\_

Do you participate in sports? \_\_\_\_\_ What type? \_\_\_\_\_ How often? \_\_\_\_\_

Do you have any hobbies? \_\_\_\_\_ What are they? \_\_\_\_\_

## **FAMILY HEALTH HISTORY**

Father's age: \_\_\_\_\_ If deceased, cause and age at death: \_\_\_\_\_

Mother's age: \_\_\_\_\_ If deceased, cause and age at death: \_\_\_\_\_

Total number of brothers and sisters: \_\_\_\_\_ Number of siblings deceased: \_\_\_\_\_

**Have any of your relatives had the following diseases? Check all that apply and note their relationship to you and their age at time of diagnosis.**

High Blood Pressure \_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

Diabetes \_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

Heart Disease \_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

Cancer \_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

Other Illness \_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

## **IN CASE OF EMERGENCY**

If an emergency arose, whom would you like us to notify?

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

## **PAYMENT INFORMATION**

Cash \_\_\_\_ PIP/Auto \_\_\_\_ Worker's Comp \_\_\_\_ Medicare \_\_\_\_ Medical \_\_\_\_

Insurance Company: \_\_\_\_\_ Policy#: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Agent's Name: \_\_\_\_\_ Claim #: \_\_\_\_\_

Were you referred by an attorney? Y N

Attorney's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_