New Patient Health History Form

Curtis R. Kannegieter, D.C. **Chiropractor** **303-730-3174**

To provide the best possible wellness care, please complete and bring this form to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name: ____ Date: ______________________________

Date of Birth: _______________________________________ Current Age: ________________________

Primary Phone: ________________________ Email: __________________________________

Address: ____City: ____________________Zip: ______

Occupation: _________________________ Employer: ____

Marital Status: ________________________ Spouse's Name: ____________________________________

Emergency Contact: ____ Phone: _______________________

Referred by: ____

Insurance:

Name of Company: ____

If auto crash, please provide:

Name of company: ____

Adjuster: ____________________________________ Phone: ______________________________________

Claim number: ____

Current Complaints:

Please describe: ____

Date of injury: _________________________ Automobile? _________ Work? ______ Other? ________

Have you experienced this before? ______ When? ____

What activities aggravate your symptoms?

Pain	No	Yes
Do you experience pain every day?		
Do your symptoms interfere with daily life?		
Does pain wake you up at night?		
Are your symptoms worse during certain times of the day?		
Do changes in weather affect your symptoms?		
Do you wear orthotics?		
Do you take vitamin supplements?		

Have you been under previous chiropractic care? ______ Describe:

 Signature ____ Date ____________________________________

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Name: ____ Date: ______________ Alt: ___________

Habits	None	Light	Moderate	Heavy
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				
Soft drinks				
Water				
Salty Foods				
Sugary Foods				
Artificial Sweeteners				

Please check (box to the left) any applicable current/past conditions:

	Alcoholism		Constipation		Heat/cold intolerant		Pacemaker
	Allergies		Cramps		Hot flashes		Polio
	Anemia		Depression		Irregular heart beat		Poor posture
	Anxiety		Diabetes		Irregular cycle		Prostate trouble
	Arteriosclerosis		Digestion issues		Joint pain/swelling		Sciatica
	Arthritis		Dizziness		Kidney infection		Shortness of breath
	Asthma		Ears ringing		Kidney stones		Sinus infection
	Back Pain		Excess menstruation		Loss of memory		Sleep problems
	Breast lump		Excess thirst/hunger		Loss of balance		Spinal curvatures
	Bronchitis		Eye pain		Loss of smell		Stroke
	Bruise easily		Fatigue		Loss of taste		Swelling in ankles
	Cancer		Frequent urination		Loss of vision		Thyroid condition
	Chest pain/condition		Hair/nail changes		Muscle pain/cramps		Tuberculosis
	Cold extremities		Headache		Neck pain/stiffness		Ulcers
			Hearing difficulty		Nervousness		Varicose veins
			Hemorrhoids		Nosebleeds		Venereal Disease
			High Blood Pressure				Weight loss/gain

 Signature ____ Date ______________________________________

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Medical History

Current medical conditions (Describe conditions you have received treatment for in the past year):

Current medications:

Current supplements/ vitamins:

Past Conditions

Surgeries –

Broken Bones -

Hospitalizations –

Family History – List past/present health conditions (heart disease, cancer, diabetes, arthritis etc.):

 Signature ____ Date ____________________________________