

# Confidential New Patient Health Record

DATE: \_\_\_\_\_

## PERSONAL HISTORY

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male Female  
Social Security #: \_\_\_\_\_  
Social Insurance #: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Business Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_  
Business Phone: \_\_\_\_\_  
Name of Spouse: \_\_\_\_\_ Spouse's Social Security #: \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Type of Work: \_\_\_\_\_ Name and Ages of Children: \_\_\_\_\_  
Referred To This Office By: \_\_\_\_\_  
Name and Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Who is Responsible for Your Bill, You and Spouse Workers' Comp. Auto Insurance Medicare Medicaid  
Personal Health Insurance (Name) \_\_\_\_\_ Health Card # \_\_\_\_\_  
Insured Person's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## CURRENT HEALTH CONDITION

Unwanted health condition(s): \_\_\_\_\_  
Other Doctors seen for this condition(s): YES NO Who? \_\_\_\_\_  
Type of treatment: \_\_\_\_\_ Results: \_\_\_\_\_  
When did this condition(s) begin? \_\_\_\_\_ Has this condition(s) occurred before? YES NO  
Is condition(s): Job related Auto accident Home injury Fall Other: \_\_\_\_\_  
Date of accident: \_\_\_\_\_ Time of accident: \_\_\_\_\_  
Have you made a report of your accident to your employer: YES NO  
Drugs you now take: Nerve Pills Pain killers/Muscle relaxers Blood pressure medicine Insulin  
Other: \_\_\_\_\_  
Do you wear a shoe lift? YES NO  
Do you suffer from any condition other than that which you are now consulting us? \_\_\_\_\_  
\_\_\_\_\_

## PAST HEALTH HISTORY

Please circle and describe:  
Major surgery/operations: Appendectomy Tonsillectomy Gall bladder Hernia Back surgery Broken bones  
Other: \_\_\_\_\_  
Major accidents or falls: \_\_\_\_\_  
Hospitalization (other than above): \_\_\_\_\_  
Previous Chiropractic care: None Doctor's name & approximate date of last visit: \_\_\_\_\_

**Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.**

### CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- |  |   |                                    |
|--|---|------------------------------------|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps            | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox        | <input type="checkbox"/> Pleurisy  |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Epilepsy  |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Mental disorders | <input type="checkbox"/> Lumbago   |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Heart disease    | <input type="checkbox"/> Eczema    |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Thyroid          | <input type="checkbox"/> Anemia    |

Have you been tested HIV positive? Yes No

### DO YOU CONSUME THE FOLLOWING:

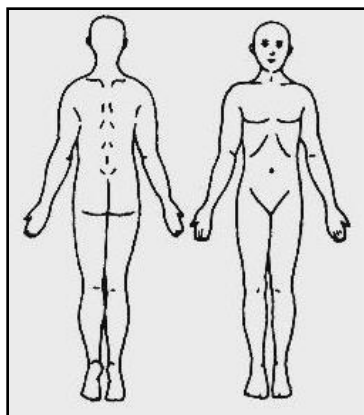
- Cigarettes
- Coffee
- Tea
- Alcohol
- White Sugar

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

REVIEW OF SYSTEMS- Please fill out all of the sections, even if "DENY"

Please outline on the diagram the area of discomfort

A=Aches B=Burning N=Numbness  
P=Pins & Needles S=Stabbing O=Other



**Constitutional: I....** Deny any constitutional issue(s)

- Chills
- Weight gain
- Weight loss
- Daytime somnolence (drowsiness)
- Fatigue
- Fever
- Night sweats

**Eyes/Vision: I....** Deny any eyes/vision issue(s)

- Blindness
- Eye pain
- Tearing
- Cataracts
- Change in vision
- Double vision
- Blurred vision
- Field cuts (visual field defect)
- Wears glasses/contact lenses
- Glaucoma
- Itching (around eyes)
- Photophobia

**Ears, Nose & Throat: I....** Deny any ears, nose & throat issue(s)

- Bleeding
- Headaches
- Snoring
- Ear drainage
- Ear pain
- Dentures
- Hearing loss
- Tinnitus (ringing in ears)
- Nose bleeds (frequent)
- Dizziness
- Nasal congestion
- Dental implants
- Head injury
- Ear infections
- Post nasal drip
- Sinus infections
- TMJ problems
- Fainting
- Loss of smell
- Discharge
- Rhinorrhea (runny nose)
- Difficulty swallowing
- Hoarseness

**Respiration: I....** Deny any respiration issue(s)

- Asthma
- Coughing up blood
- Sputum production
- Cough
- Shortness of breath
- Wheezing

**Gastrointestinal: I....** Deny any gastrointestinal issue(s)

- Abdominal pain
- Nausea
- Belching
- Rectal bleeding
- Hemorrhoids
- Constipation
- Vomiting blood
- Jaundice
- Difficulty swallowing
- Abnormal stool
- Heartburn
- Black, tarry stool
- Vomiting
- Indigestion
- Diarrhea
- Abnormal stool color

**Endocrine: I....** Deny any endocrine issue(s)

- Cold intolerance
- Voice changes
- Goiter
- Hair loss
- Heat intolerance
- Unusual hair growth
- Frequent urination
- Diabetes
- Excessive appetite
- Excessive hunger
- Excessive thirst

**Nervous System: I....** Deny any nervous system issue(s)

- Dizziness
- Facial Weakness
- Headaches
- Limb Weakness
- Loss of Consciousness
- Loss of memory
- Numbness
- Seizures
- Sleep disturbances
- Loss of memory
- Strokes
- Tremors
- Unsteadiness of gait
- Slurred speech
- Stress

**Allergy: I....** Deny any allergy system issue(s)

- Anaphylaxis(history of)
- Itching
- Sneezing
- Food intolerance
- Nasal congestion

**Cardiovascular: I....** Deny any cardiovascular issue(s)

- Angina(chest pain)
- Heart problems
- Palpitations(irregular or forceful beating of heart)
- Paroxysmal nocturnal dyspnea (waking at night with shortness of breath)
- Shortness of breath with exertion or exercise
- Ulcers
- Swelling of legs
- Varicose veins

**Female: I....** Deny any female issue(s)

- Birth control therapy
- Burning urination
- Frequent urination
- Irregular menstruation
- Vaginal bleeding
- Breast lumps/pain
- Cramps
- Hormone therapy
- Urine retention
- Vaginal discharge

Are you pregnant? Yes/No Date of last period: \_\_\_\_\_

**Male: I....** Deny any male issue(s)

- Burning urination
- Prostate problems
- Frequent urination
- Erectile dysfunction
- Urine retention
- Hesitancy/dribbling

**Skin: I....** Deny any skin issue(s)

- Changes in nail texture
- Hair growth
- Itching
- Rash
- Skin lesions/ulcers
- Changes in skin color
- Hair loss
- Paresthesia(numbness, prickling or tingling)
- History of skin disorder
- Varicosities
- Hives

**Psychological: I....** Deny any psychological issue(s)

- Anhedonia
- Confusion
- Depression
- Behavioral changes
- Bipolar disorder
- Convulsions
- Memory loss
- Appetite changes
- Mood changes
- Anxiety
- Insomnia

**Hematology: I....** Deny any hematology issue(s)

- Anemia
- Blood transfusion
- Lymph node swelling
- Bleeding
- Fatigue
- Blood clotting
- Bruises easy

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: YES NO Referred

Doctor's Signature

## Informed Consent for Treatment and Care

I hereby request and consent to the performance of medical services , examinations, chiropractic adjustments and other procedures (including various modes of physical therapy and diagnostic x-ray), or physical therapy on me (or the patient named below, for whom I am legally responsible) by the doctors of Better Life Wellness Center, and/or other licensed clinic doctors who now or in the future treat me while employed by, are working or associated with, or serving as a back-up doctor, including those working at the clinic. I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of medical services and examinations, chiropractic adjustments, and other procedures. I authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I also understand my responsibility to inform this office of any changes in my medical status.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire of my treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Consent to treat a Minor \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse's  
Signature of Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_

# Better Life Chiropractic & Wellness

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John Reitz, DC, CSCS

