New Patient Health History Form

In order to provide you the best possible care, please complete this form.
All information is strictly CONFIDENTIAL.

Patient Data

First Name_____Last Name_____ Date _____

Email*_____
Your email will NOT be shared with any 3rd parties, and is used for sending and receiving paperwork, Myovision Scan

Mailing Address

Address _____City_____State_____Zip_____

Telephone (Home) _____ (Cell) _____ (Work) _____

Age_____ Birth Date_____ Number of Children_____ Height_____

Weight_____ Marital Status: ___ Married ___ Single ___ Widowed ___ Divorced

Occupation_____ Employer_____

Current Complaints

Nature of Injury: □ Automobile* □ Work □ Other

Please describe:_____

Date of injury_____ Date symptoms appeared_____

Have you ever had same condition? □ No □ Yes If Yes, when? _____

List of other practitioners seen for this injury/condition_____

Have you ever been under chiropractic care? □ No □ Yes If Yes, please describe_____

Signatures

I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.
Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? □ No □ Yes

If yes, please describe _____

Date of last physical exam_____ Is there a chance that you are pregnant? □ No □ Yes

Have you had X-rays taken? □ No □ Yes If Yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc)_____

_____

What vitamins, minerals, or herbs you currently take? (Please list for what conditions, dosage, and frequency)_____

_____

Have you ever:	No	Yes	Briefly Explain
Broken bones?	☐ No	☐ Yes	_____
Been hospitalized?	☐ No	☐ Yes	_____
Been in an auto accident?	☐ No	☐ Yes	_____
Had Sprains/Strains?	☐ No	☐ Yes	_____
Been struck unconscious?	☐ No	☐ Yes	_____
Had surgery?	☐ No	☐ Yes	_____

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)_____

_____

_____

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

What activities aggravate your symptoms? _____

_____

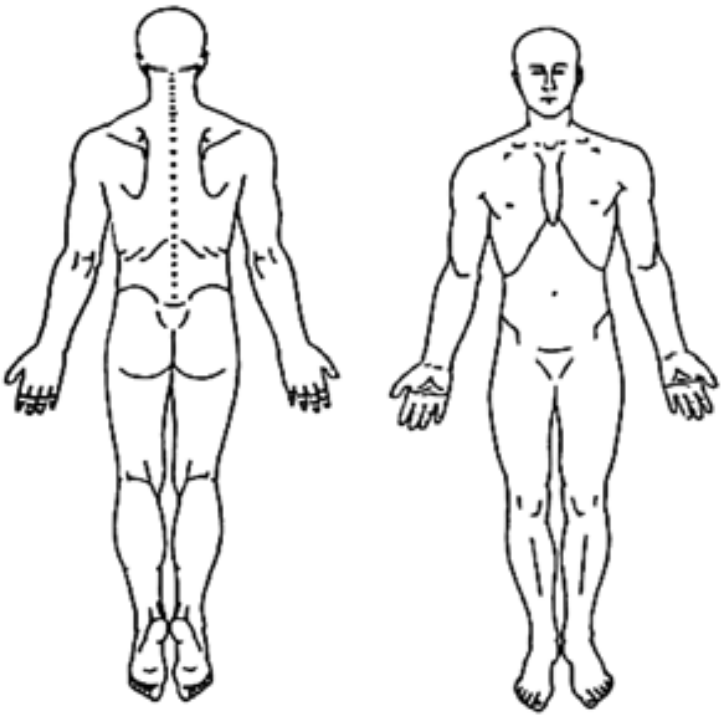
Habits	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

Have you ever suffered from:

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Constipation
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ringing
- Excessive or Irregular Menstruation
- Eye Pain or Difficulties
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Kidney Infection or Stones
- Loss of memory
- Loss of balance
- Loss of smell or taste
- Neck Pain or Stiffness
- Nosebleeds
- Pacemaker
- Prostate Trouble
- Sciatica
- Sinus Infection
- Sleep problems or Insomnia
- Spinal Curvatures
- Stroke
- Swollen Joints
- Thyroid Condition
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

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



Boise Family Wellness
Terms of Acceptance

Chiropractic:
Chiropractic seeks to restore health through natural means without the use of medicine or surgery. This gives the body the maximum opportunity to utilize its inherent recuperative powers. The success of chiropractic depends on the environment, underlying irritants, physical and spinal problems.

Analysis:
Boise Family Wellness conducts a thorough chiropractic evaluation and utilizes the most recent research evidence and technology to develop a solution for each patient.

Diagnosis:
Dr. Jen will, when necessary, refer you to other physicians for consultation and/or additional work up. While Dr. Jen is an expert in spinal subluxations and misalignments throughout your body, each patient should secure on their own other opinions if the patient has additional concerns about their health.

Informed Consent:
Dr. Jen utilizes Activator Methods Chiropractic Technique to adjust patients' spinal subluxations and other misalignments throughout the body. Dr. Jen adjusts patients in an open setting to minimize patient wait time, to keep staff involved in patient care and to allow for easier discussion of chiropractic tenets. If the patient is uncomfortable with this style of adjusting please inform the front desk upon arriving and you will be provided with a private room. If you have a question for Dr. Jen and you would like more privacy, let the doctor or staff know and time will be available to discuss your question.

Results:
The purpose of chiropractic is to promote health through the reduction of subluxations or misalignments using Activator Methods Chiropractic Technique. Since there are so many different variables, it is difficult to predict outcomes. Sometimes response is phenomenal. In most cases response is gradual but satisfactory. And occasionally response is less than expected. Two or more similar conditions often respond differently to chiropractic adjustments.

To The Patient:
Please discuss any questions or concerns with Dr. Jen or a staff member before signing this policy.

I have read and understand the foregoing.

_____ _____

Signature Date

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at Boise Family Wellness, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_____ _____

Patient Name (printed) Relationship to patient

_____ _____

Patient or legal Guardian Signature Date

_____ _____

Witness Signature (office staff) Date