OPTIMAL WELLNESS Chiropractic & Nutrition

Canton Center Chiropractic Clinic

Patient Health History Form

Confidential

Date	Number	X-ray

Patient Information

Name: _____

SS#: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Occupation: _____

Employer: _____

Spouse's Name: _____

Age(s) of Children: _____

Referred By: _____

Insurance

PRIMARY INSURANCE

Insurance Co.: _____

Subscriber Name: _____

Subscriber Birthdate: _____

Relationship to patient: _____

Do you have a Health Spending / Flex Plan: ☐ Yes ☐ No

Do you have a Secondary Insurance: ☐ Yes ☐ No

SECONDARY INSURANCE

Insurance Co.: _____

Subscriber Name: _____

Subscriber Birthdate: _____

Relationship to patient: _____

Phone Numbers

Primary Phone: _____ ☐ Cellular/Mobile ☐ Home ☐ Work/Business

Secondary Phone: _____ ☐ Cellular/Mobile ☐ Home ☐ Work/Business

Cell Carrier: _____ E-Mail: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name of Emergency Contact Person: _____ Relationship to Patient: _____

Primary Phone: _____ ☐ Cellular/Mobile ☐ Home ☐ Work/Business

Secondary Phone: _____ ☐ Cellular/Mobile ☐ Home ☐ Work/Business

Current Health Condition

Primary Complaint: _____

When did this condition begin? _____ Has this condition occurred before? ☐ Yes ☐ No

Rate the Pain from 1 (least pain) to 10 (severe pain): _____ Does the condition occur: ☐ Daily ☐ Weekly ☐ Monthly

Is the persistance of this condition: ☐ Intermittent (0-25% of the time) ☐ Occasional (26-50% of the time) ☐ Frequent (51-75% of the time) ☐ Constant (76-100% of the time)

Please list other doctors you have seen for this condition: _____

Type of Treatment: _____ Results: _____

Is this condition related to: ☐ Work Accident ☐ Auto Accident ☐ Home Injury ☐ Stumble/Fall ☐ Other: _____

Date and Time of Accident: _____

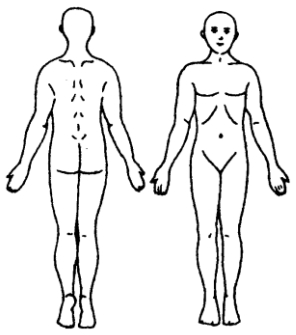
With whom have you filed a report/claim:

☐ Auto Insurance ☐ Employer ☐ Workman's Comp. ☐ None

Please list all Drugs which you currently take: _____

Please list all Supplements which you currently take: _____

List any other health complaints (not listed above): _____



Please outline on the diagram the area of your discomfort