TENPENNY
Chiropractic Associates
Wellness awaits you...

100 Burnsed Place Suite# 1020
Oviedo, Florida 32765
(407)-971-3898

CONFIDENTIAL NEW PATIENT HEALTH HISTORY FORM

Personal Information:

Last Name: ___________________________ First Name: ____________________ Middle Initial: ______

Address:_________________________________ City:_________________ State:_____ Zip:___________

Home Phone:_________________ Cell Phone:__________________ Work Phone:_________________

E-Mail Address: _____________________________________ Social Security #: ____________________

Date of Birth:___________ Age:_____ Sex: Male / Female Marital Status: Married / Single / DIV / WID

Employer: ______________________ Employer Address: ______________________________________

Employed: Full Time / Part Time / Retired Student: Full Time / Part Time / Not Applicable

Spouse Name:__________________________ Spouse Date of Birth: ___________________________

Spouses Employer:______________________________ Referred By: ____________________________

Insurance Information:

Type of Insurance: □ Private Ins. □ Medicare □ Auto Ins. □ Worker's Comp
□Other__________________________________

Primary Insurance Carrier:____

Phone:_____________________________

Policy#_____________________________

Group #____________________________

Claim#_____________________________

Name of Policy Holder:____

Relationship to Patient:__________________________

Policy Holder's Birthdate :______/_____/______ Policy Holder's SSN: ______/____/______
Employer:_______________________

Is patient covered by another insurance? □ Yes □ No

Secondary Insurance Carrier:___________________Policy #:_____________

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand if I suspend or terminate my care/treatment, any fees or professional services rendered to me will be immediately due and payable.

Patient, Patient, or Legal Guardian Signature: _______________________________ Date: ____________

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Reason For Visit:

Primary/Main Complaint:________________________ What caused this complaint?_________________
Is this related to an automobile accident or work injury? □Yes □No If yes, date of accident: ___/___/___

When did this complaint begin? ___/___/___ **Is it getting worse?** □Yes □No

My Complaint is: □Constant □Comes and goes **My complain is worse:** □ End of day □ Beginning of day

Have you had this or similar complaint in the past? □ Yes □ No If "Yes", when?________________

What does your complaint (s) feel like? **Circle all** that apply: *Sharp/ Dull/ Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other*________________

On the scale below, please circle the severity of your main complaint right now:

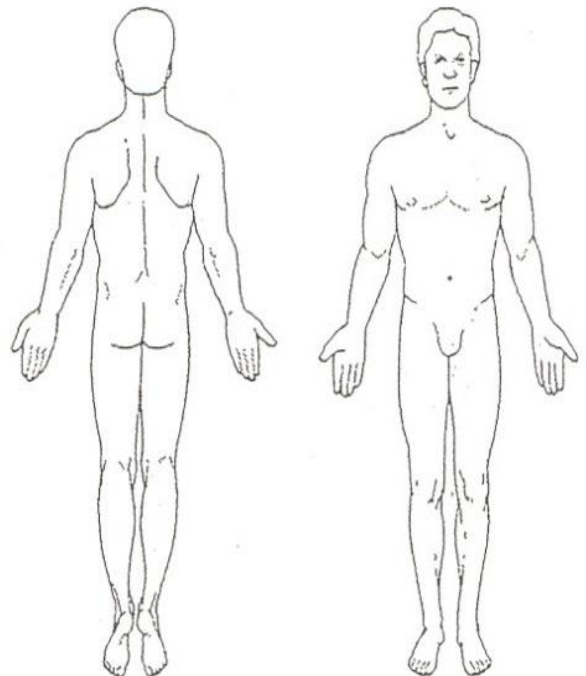
No Pain (0) ***Moderate Pain (5)*** ***Worst Possible Pain (10)***

0	1	2	3	4	5	6	7	8	9	10

Have you seen anyone else for this complaint? □ Yes □ No If "Yes", who? ___________________

Have you ever been under chiropractic care? □ Yes □ No If "Yes", please describe ________________

Please mark with an "X" on the diagram to the right the location where you are experiencing pain or other symptoms.



Does your pain radiate/travel?

□ Yes □ No If "Yes", please describe _______________

____

What aggravates your symptoms? _________________

____

What relieves your symptoms? ____________________

____

How often do you experience these symptoms throughout the day? □100% □75% □50% □25% □10% □Only with activity _______________

What activity makes your complaint worse? *Sitting/Standing/Walking/Sleeping/Exercising/Lifting/Bending*

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Medical History:

	Please check **ALL** of the health conditions below that apply to **you** currently or in the past.				**Family History** Mark **ALL** conditions that run in your family	Relationship: (Father,Mother,Sister,Brother)
□	Osteoarthritis/Degenerative Joint Disease	□	Whiplash Injury *Date of injury:*	□	Cancer *Type:*	
□	Asthma	□	Headaches	□	Anemia	
□	Diabetes □ Type I □ Type II	□	Kidney Infection or Kidney Stones	□	Diabetes (check one) □Type I □ Type II	
□	Anemia	□	Migraines	□	Heart Problems / Stroke	
□	Cancer/Tumor Type: _______________	□	Osteoporosis /Osteopenia	□	High Blood Pressure	
□	Rheumatoid Arthritis	□	Epilepsy / Seizures	□	Genetic Disorders	
□	Depression/ Anxiety	□	Fibromyalgia / Chronic Fatigue	□	Rheumatoid Arthritis	
□	Disc Herniation Location: _____________	□	Genetic Disorders	□	Other (List):	
□	High Blood Pressure /Hypertension	□	Pacemaker/Defibrillator/Electric Device			
□	Heart Disease / Stroke		Please list any other medical conditions: __________________			

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

____

____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

____

____

Have you had an X-ray or CT scan or MRI? □ Yes □ No If "yes", please describe (list body region & date)? ____

FEMALES: Is there a chance that you are pregnant? □ Yes □ No

List current prescription medications, including frequency and dosage if known.

If there are NO current medications, check here □

Name of prescription medication	*Dosage*	4.	*Dosage*
1.		5.	
2.		6.	
3.		7.	

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Social History:

Do you exercise? □ Yes □No How often? __________

Do you smoke? □ Yes □ No If yes, how many packs per day?______ How long? ____________________
Do you drink alcohol? □ Yes □ No How often? _____________________

Do you drink coffee? □Yes □No If yes, how many cups per day? __________________________

Do you drink soda? □Yes □No If yes, how many per 12 oz. servings per day? _____________________
Do you drink water? □Yes □No If yes, how much per day?_______________________________

Do you eat vegetables and fruits? □Yes □No

Do you take any supplements (i.e. vitamins, minerals, herbs)? □Yes □No If yes, list the supplements you are taking: ____