Horace Family Chiropractic, PC
534 North Main Street
Horace, ND 58047

(701) 532-3100
Fax: (701) 532-3101
www.horacefamilychiro.com

New Patient Health History Form

At Horace Family Chiropractic our primary focus is on your overall health. Please be specific so that we can address your primary concern for visiting us today. The following questions will also give us a profile of the specific stresses you have faced over your lifetime that may be impacting your health today or in the future. All information is confidential.

General Patient Information

Name (last, first) ____

Birth Date ______________ Age ______ Sex ___male () female ()___

Phone # (cell)______________________ (home/work)___________________________

Email Address ____

Mailing Address _____________________________________

____

Occupation ______________________________ Employer _________________________

Marital Status _________________ Spouses Name (if applicable) ___________________

Children-Names & Ages (if applicable) ____________________________________

____

Did someone refer you to us? If so, please write down their name(s) so we can thank them

____

Emergency Contact _____________________________ Phone # ____________________

Insurance Information

Do you have health insurance? () yes () no

Name of company ________________________

Policy ID _________________________________

-Although most policies cover chiropractic, the frequency of care and amount reimbursed varies and is not guaranteed. Regardless of your health insurance coverage, Horace Family Chiropractic believes in recommending the care you need to get well and stay well. In signing the above, I understand and agree that my health/accident insurance policies are an arrangement between the insurance carrier and myself. All services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable to Horace Family Chiropractic. -

Signature _____________________________________ Date_________________

If auto accident, worker's compensation, or personal injury case please specify:

Contact Person ___________________________ Phone # ____________________

Claim # __________________Name of Insured _____________________________

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Current Health Profile

Reason for today's visit () Wellness () Automobile ()Work Related () Other
Please Describe ____
____

Injury Date(if applicable) ____________ Symptom Onset Date(if applicable) ____________

Have you ever experienced this complaint before? Circle One. Yes / No
If so, any sought treatments/providers? ______________________________

Has this complaint progressed in nature since the initial onset? Better / Worse / Same

Where do you feel the pain/symptoms? Please be specific______________________
____

Describe the quality of your complaint (if applicable)
() Dull
() Achy
() Sharp/Stabbing
() Throbbing
() Numbness
() Tingling
() Radiating – where? __________

How often do you feel pain/symptoms?
() Occasionally(a few times/month)
() Intermittently (1-2 times/week)
() Frequently (3-5 times/week)
() Constantly (every day)

Rate the intensity of your pain/symptoms. Circle one. 0=no pain at all, 10=worst pain imaginable
At its worst = 0 1 2 3 4 5 6 7 8 9 10
At its best = 0 1 2 3 4 5 6 7 8 9 10
Sitting here today = 0 1 2 3 4 5 6 7 8 9 10

What makes the pain/symptoms better? ______________________________
worse?______________________________

Does this complaint interfere with your everyday living? Check all that apply.
() limits me at work
() limits my family activities
() interferes with chores around the home
() alters my mood
() interferes with my sleep
() keeps me from doing something that I used to do/would like to do
Explain:______________________________

What else would you like to discuss with the Dr. today to help you on your health journey?
() Weight Loss
() Exercise
() Stress Management
() Sleeping Difficulties
() What can chiropractic do for my children/spouse?
() Diet Tips/Supplement Questions
() Ask the Dr. to do a health talk at work or for friends
()Other ______________________________

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Health History

Please check all that apply to your past or current health

____ Aids/HIV
____ Alcoholism
____ Allergies List: ________________________
____ Anemia
____ Anxiety
____ Arthritis
____ Asthma
____ Bladder Infections
____ Bleeding Disorders
____ Breast Lumps
____ Blood Pressure High / Low
____ Cancer
____ Circulatory Problems List: ____________
____ Cholesterol High / Low
____ Congenital Disease List: _______________
____ Constipation
____ Depression
____ Diabetes Type I / Type II
____ Diarrhea
____ Digestive Problems
____ Dizziness
____ Eating Disorder
____ Epilepsy
____ Excessive Thirst
____ Fainting
____ Fatigue
____ Fever
____ Fractures
____ Gallbladder Problems
____ Gas/Bloating After Meals
____ Headaches
____ Heartburn

____ Hernia
____ Herniated Disc List: ______________
____ Hypertension
____ Joint Pain
____ Kidney Disease
____ Liver Disease
____ Miscarriage
____ Mononucleosis
____ Nausea
____ Night Pain
____ Night Sweats
____ Numbness
____ Obesity
____ Osteoporosis
____ Pacemaker
____ Pinched Nerve
____ Pneumonia
____ Ringing in Ears
____ Scoliosis
____ Skin Problems (acne, excema, sensitive)
____ Sleep Disorder
____ Shortness of Breath
____ Stroke
____ Swelling of Feet/Ankles
____ Thyroid Disease hyper / hypo
____ Tuberculosis
____ Unexplained Weight Loss
____ Urinary Tract Infection (UTI)
____ Urinary Problems
____ Vision Problems
____ Vomiting

Females Only:
____ Menstrual Irregularity
____ Menstrual Cramping/Bloating
____ Yeast Infection
Are you pregnant? Yes / No / Not Sure
Number, Dates, and Outcomes of Pregnancies: ____
____

Do any members of your family have any of the above illness or other serious health concerns?
Please explain all that apply ____

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Medications

Prescription : ____Reason:________
____Reason:________
Over-the-counter: ____
Supplements: ____

Injuries/Accidents

Type | Date
____ ________
____ ________
____ ________

Surgeries/Hospitalizations

Reason | Date
____ ________
____ ________
____ ________

Lifestyle

How many hours of sleep do you average per night? ________
Do you feel rested in the morning? () yes () no
How often do you consume caffeinated beverages? () everyday () some days () not at all
How often do you consume alcoholic beverages? () everyday () some days () not at all
Are you a smoker? () yes () no
How often do you exercise? () 5-7 days/wk () 3-5 days/wk () 1-3 days/wk
() less than 1 day/wk () never
What do you like to do for exercise or to stay active in your day? ________________
____
What does your job consist of? () physical labor
() standing most of the day
() sitting most of the day
() varies (physical some days, stationary others)
How much stress are you under most of the time? () low () high Reason ________

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CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND/OR HEALTHCARE OPERATIONS

"Protected health information" means information about you, including demographic information such as your address and phone, age, gender, etc., that may identify you and relates to your past, present, or future physical or mental health or condition and related healthcare services.

In signing this document I consent to the use or disclosure of my protected health information by Horace Family Chiropractic, PC for the purpose of diagnosis or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of the clinic. I understand that Dr. Sundby/Dr.Schultz and Horace Family Chiropractic, PC may refuse to diagnose or treat me if I do not consent to the use or disclosure of my protected health information for the above stated purposes.

The "Notice of Privacy Practices" is a document that describes the type of uses and disclosures of your protected health information that will occur in your treatment, payment of your bills, and in the performance of healthcare operations of the clinic.

In signing this document I acknowledge that a copy of the Notice of Privacy Practices has been made available to me and I have been informed that I have the right to review the Notice prior to signing this document.

I understand that I have the right to request that the clinic restrict how my protected health information is used and/or disclosed to carry out treatment, payment and/or healthcare operations. I understand that the clinic is not required to agree to any restrictions that I have requested, but if the clinic agrees to a requested restriction, then the restriction is binding on the clinic.

I understand that I have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that such revocation shall not apply to actions already taken by the clinic based on this consent document.

Horace Family Chiropractic, PC reserves the right to change the privacy practices described in the "Notice of Privacy Practices" document. Any revisions to the Notice will be made available to you at your request and will be posted in the reception area.

I have read and understand the foregoing notice and my questions have been answered to my full satisfaction.

__________________________ _______________________________
Name of patient Signature of patient/legal representative

____
Date Signed