New Patient Health History Form

In order to provide you the best possible care, please complete this .
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 occasional office announcements and promotions

Mailing Address

Address City State Zip

Telephone (Home) (Cell) Referred By

Age Birth Date Marital Status ☐ S ☐ M ☐ D ☐ W Number of Children

Occupation Employer

Spouse's Name Spouse's Occupation

Spouse's Employer Spouse's Health Status

Emergency Contact Phone

Current Complaints

Reason(s) for visit:

1.
2.
3.
4.
5.

Have you ever been under chiropractic care ☐ Yes ☐ No

If yes, please describe:

Medical History

Have you ben treated for any conditions in the last year? ☐ Yes ☐ No

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? ☐ Yes ☐ No

Have you had X-rays taken? ☐ Yes ☐ No If yes, where?

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

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

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

Family History
Family Members - Present and past health conditions.

Quality of Life	Yes	No	Explain if necessary
Do you experience pain every day?	☐	☐	
Do your symptoms interfere with daily life?	☐	☐	
Does pain wake you up at night?	☐	☐	
Are your symptoms worse during certain times of the day?	☐	☐	
Do changes in weather affect your symptoms?	☐	☐	
Do you wear orthotics?	☐	☐	
Do you take vitamin supplements?	☐	☐	
What activities aggravate your symptoms? (write below)			

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

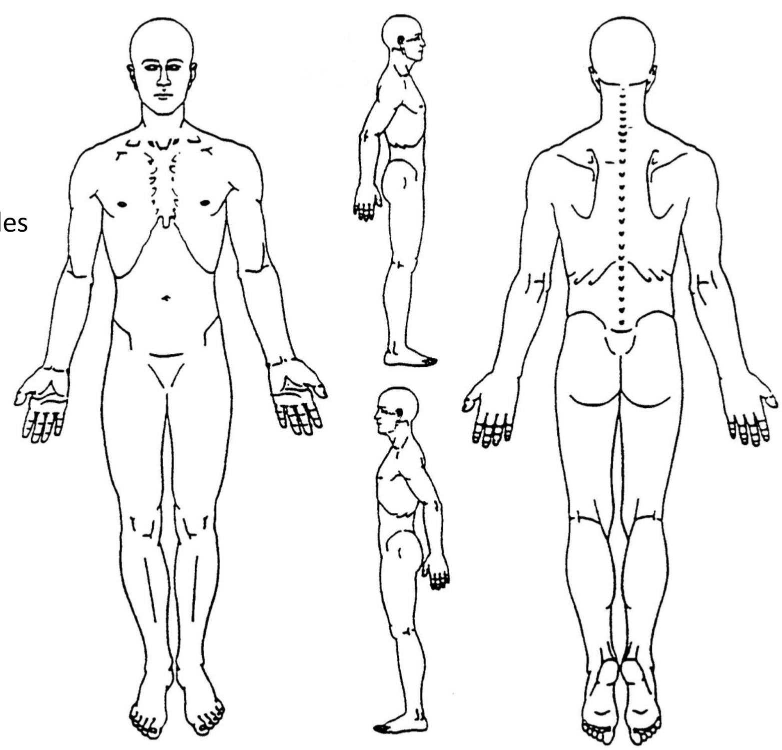
Have you ever suffered from:

1. Glandular Conditions	2. Eliminative Conditions	3. Nervous Conditions
☐ Excessive Menstruation	☐ Allergies	☐ Anxiety / Nervousness
☐ Fatigue	☐ Asthma / Shortness of Breath	☐ Depression
☐ Frequent Colds / Flu	☐ Bronchitis / Pneumonia	☐ Dizziness
☐ Hot Flashes	☐ Constipation	☐ Ears Ringing
☐ Infertility / Pregnancy Issues	☐ Frequent Urination	☐ Eye Pain or Difficulties
☐ Irregular Cycle	☐ Hemorrhoids	☐ Loss of Memory
☐ Prostate Trouble	☐ Kidney Infection / Stones	☐ Loss of Smell
☐ Thyroid Condition	☐ Sleep Apnea	☐ Loss of Taste
	☐ Sinus Problems	☐ Numbness / Tingling in Hands
	☐ Skin Conditions	☐ Numbness / Tingling in Feet
	☐ Urinary Tract Infections	☐ Poor Sleep or Insomnia

4. Digestive Conditions	5. Muscular Conditions	6. Circulatory Conditions
☐ Alcoholism	☐ Arthritis	☐ Arteriosclerosis
☐ Anemia	☐ Back Pain or Stiffness	☐ Bruise Easily
☐ Crohn's Disease / IBS	☐ Cramps / Spasms	☐ Cold Extremities
☐ Diabetes	☐ Loss of Balance	☐ High or Low Blood Pressure
☐ Headache	☐ Neck Pain or Stiffness	☐ Irregular Heartbeat
☐ Heartburn	☐ Pain in Chest	☐ Migraines
☐ Liver / Gall Bladder Problem	☐ Pain in Extremities	☐ Nosebleeds
☐ Reflux	☐ Sciatica	☐ Pacemaker
☐ Ulcers	☐ Spinal Curvatures / Scoliosis	☐ Stroke
	☐ Swollen Joints	☐ Swelling of Ankles

Please use the following letters to indicate **TYPE** and **LOCATION** of the symptoms you current are experiencing:

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



For Doctor's Use

Dr. Sandra Castro
575 2nd Street
Encinitas, CA 92024

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I have had an opportunity to discuss with my chiropractor the nature and purpose of chiropractic adjustments and other procedures and have had my questions answered to my satisfaction. I understand the results are not guaranteed.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including examinations tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below, for whom I am legally responsible) which are recommended by my chiropractic and/ or other licensed Doctors of Chiropractic who now or in the future render treatment to me while working for, associated with, or serving as back-up for my chiropractor.

I understand and am informed that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then know to him or her, is in my best interest.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE
PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW

I _____ have read or _____ have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my chiropractor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treat.

Patient Name (please print): ____

____________________________________ ____________________________

Patient/Legal Guardian Signature Date

____________________________________ ____________________________

Providing D.C. Signature Date