Wellness First Chiropractic
Health History Form

Wellness First Chiropractic of Greenville

Name: Date: Cell Phone:

Address: City: State: Zip:

Sex: Date of Birth: Age: SS#

E-mail Home Phone: Work Phone:

Occupation: Employer: Number of Children:

Spouse Name: Spouse Employer: Spouse DOB:

Name of Nearest Relative (not spouse): Phone:

Who referred you to our office?

Is your visit due to an injury? YES NO If Yes: AUTO WORK OTHER

(If this visit is due to a work or auto injury, please see receptionist for special injury form)

Briefly describe any CURRENT symtoms:

Previous Chiropractors:

Medications:

Other doctors you use for healthcare:

Please check boxes that describe any symptoms you've had in the last 6 months:

- ☐Headaches
- ☐Neck Pain
- ☐Stiff Neck
- ☐Shoulder Pain
- ☐Back Pain
- ☐Chest Pain
- ☐Dizziness
- ☐Pins and Needles in hand/arms
- ☐Pins and Needles in feet/legs
- ☐Numb fingers
- ☐Numb toes
- ☐Sleeping Problems
- ☐Scoliosis
- ☐Hip Pain
- ☐Ears ringing
- ☐Loss of balance
- ☐Fainting
- ☐Head heavy
- ☐Cold hands/feet
- ☐Cancer
- ☐Digestive problems

Female Only

- ☐ Painful menstruation
- ☐Irregular cycle
- ☐Breast problems
- ☐Menopause

Are you pregnant?

☐ Yes ☐No ☐Not Sure

Do you have Insurance: YES NO Insurance Company:

ID#: Policy Group #:

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if Wellness First Chiropractic extends credit to me and I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors at Wellness First Chiropractic and whomever they may designate as their assistants; to administer treatments as they deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

Patients (Parent or Guardians) Signature: