

# New Patient Health History Form # \_\_\_\_\_

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

## Patient Data

Name \_\_\_\_\_ Date \_\_\_\_\_ Email \_\_\_\_\_  
Your email will NOT be shared with any 3d parties, and is used for general office announcements and promotions.

## Mailing address

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone #'s Hm \_\_\_\_\_ Wk \_\_\_\_\_ Cell \_\_\_\_\_  
Preferred method of contact: \_\_\_\_\_ Email \_\_\_\_\_ Text \_\_\_\_\_ Phone/Home/Work/Cell \_\_\_\_\_  
Age \_\_\_\_\_ Birth date \_\_\_\_\_ SS # \_\_\_\_\_ Ref By \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Marital Status \_\_\_\_\_ Spouse's name \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_  
Spouse's Health Status \_\_\_\_\_ Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

## Current Complaints

Nature of injury: Automobile\*  Work  Other

Please describe \_\_\_\_\_  
\_\_\_\_\_

Date of injury \_\_\_\_\_ Date symptoms appeared \_\_\_\_\_

Have you ever had same condition?  No  Yes If yes, when? \_\_\_\_\_

List other practioners seen for this injury/condition \_\_\_\_\_

Have you ever been under chiropractic care?  No  Yes

If yes, please describe \_\_\_\_\_

## Insurance Information

Name of party responsible for payment \_\_\_\_\_ Phone \_\_\_\_\_

Do you have health insurance?  No  Yes Name of company \_\_\_\_\_

*\* If an auto accident please provide:*

Insurance company name \_\_\_\_\_ Contact person \_\_\_\_\_

Phone \_\_\_\_\_ Claim # \_\_\_\_\_

## Billing Address

Name of the insured \_\_\_\_\_

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 that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's or guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

## Medical History

Have you been treated for any conditions in the last year?  No  Yes Height \_\_\_\_\_ Weight \_\_\_\_\_

If yes, please describe \_\_\_\_\_

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

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

What medications are you taking and for what conditions (Please list dosage and amounts, etc). \_\_\_\_\_

\_\_\_\_\_

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).

\_\_\_\_\_

## Have you ever:

|                           | No                       | Yes                      | Briefly Explain |
|---------------------------|--------------------------|--------------------------|-----------------|
| Broken bones?             | <input type="checkbox"/> | <input type="checkbox"/> | _____           |
| Been hospitalized?        | <input type="checkbox"/> | <input type="checkbox"/> | _____           |
| Been in an auto accident? | <input type="checkbox"/> | <input type="checkbox"/> | _____           |
| Had Sprains/Strains?      | <input type="checkbox"/> | <input type="checkbox"/> | _____           |
| Been struck unconscious?  | <input type="checkbox"/> | <input type="checkbox"/> | _____           |
| Had surgery?              | <input type="checkbox"/> | <input type="checkbox"/> | _____           |

## Family History

| Family Member | Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.) |
|---------------|--|
|               |  |
|               |  |
|               |  |
|               |  |

## Habits:

|                       | None                     | Light                    | Moderate                 | Heavy                    |  | Yes                      | No                       |
|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Alcohol               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you experience pain every day?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Coffee                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do your symptoms interfere with daily life?              | <input type="checkbox"/> | <input type="checkbox"/> |
| Tobacco               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does pain wake you up at night?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Drugs                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are your symptoms worse during certain times of the day? | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do changes in weather affect your symptoms?              | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear orthotics?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Appetite              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you take vitamin supplements?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Soft Drinks           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | What activities aggravate your symptoms?                 |                          |                          |
| Water                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | What gives relief of your symptoms?                      |                          |                          |
| Salty Foods           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____  |                          |                          |
| Sugary Foods          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____  |                          |                          |
| Artificial Sweeteners | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____  |                          |                          |

**Have you ever suffered from:**

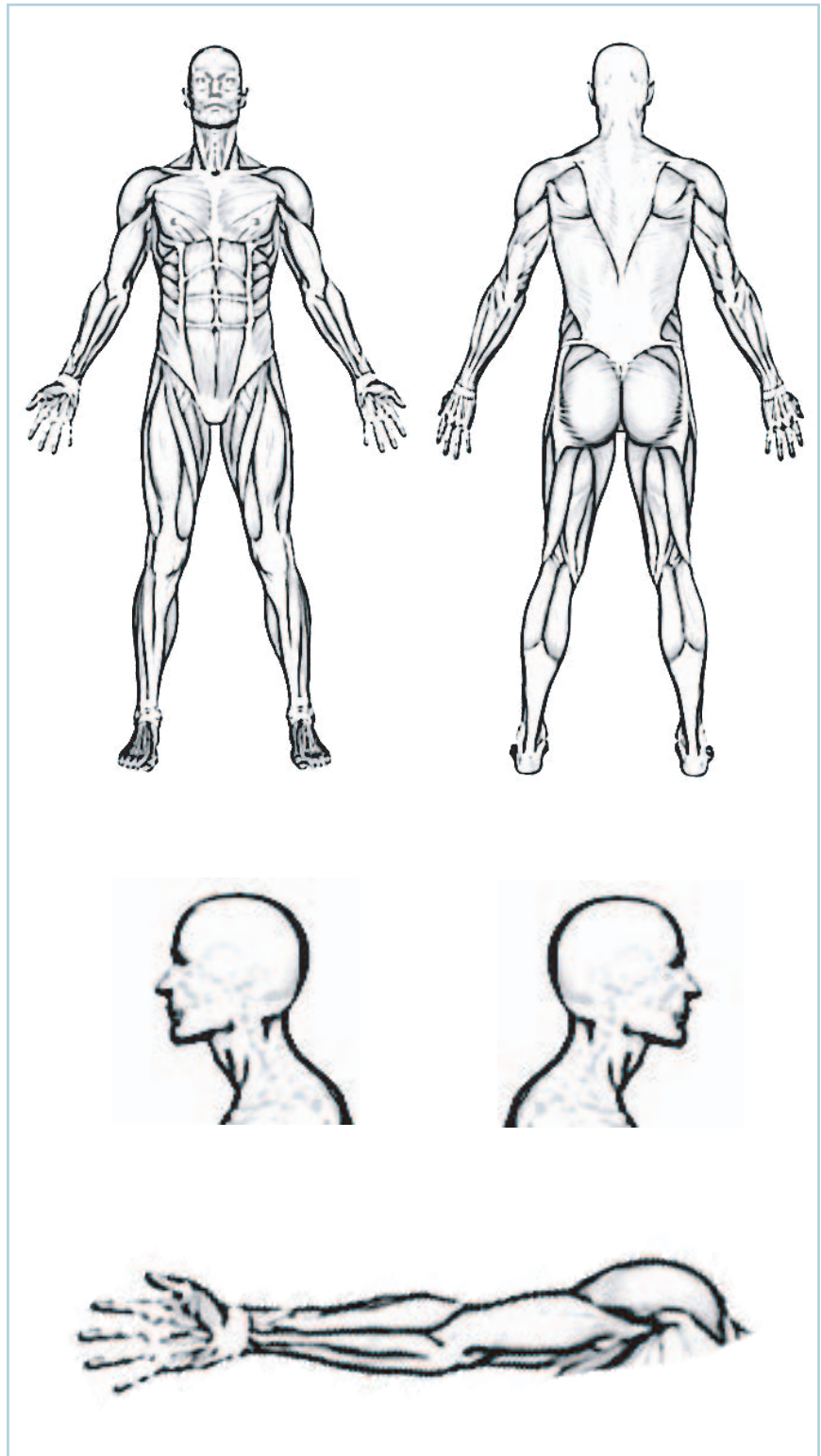
- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain/Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems/insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

**Current Complaints (Continued)**

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache  
B=Burning  
N=Numbness

O=Other  
P=Pins & Needles  
S=Stabbing





**AUTHORIZATION TO USE OR DISCLOSE  
PROTECTED HEALTH INFORMATION**

**Patient Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Date of Request:** \_\_\_\_\_

As required by the **Privacy Regulations**, this practice may not use or disclose your protected health information except as provided in our **Notice of Privacy Practices** without your authorization.

I hereby authorize this office and any of its employees to use or disclose my **Patient Health Information** to the following person(s), entity(s), or business associates:

\_\_\_\_\_

Patient Health Information authorized to be **disclosed**:

\_\_\_\_\_

For the specific purpose of (describe in detail)

\_\_\_\_\_

Effective Dates for this authorization \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_

This authorization will expire at the end of the above period.

(You may leave dates blank if authorization to the person(s) named above is for **the entire length of your treatment**)

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

**I understand I have the right to:**

1. Revoke this authorization by sending written notice to this office and that revocation will not have any effect on disclosures prior to the executions.
2. Inspect a copy of Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization if needed.
5. Restrict what is disclosed with this authorization.

\_\_\_\_\_  
**(Signature of Patient/Guardian)**

\_\_\_\_\_  
**(Date)**

\_\_\_\_\_  
**(Authorized Signature of Facility)**

\_\_\_\_\_  
**(Date)**



## Raveling Chiropractic Center, P.A.

Dr. Paul A. Raveling, D.C., P.A.  
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Telephone  
(727) 733-0433  
Fax  
(727) 738-6187

### Raveling Chiropractic Center Cancellation Policy 2011

At Raveling Chiropractic Center, your scheduled appointment time is reserved just for you. We try to book appointment times in order to provide excellent care and to be sure we have sufficient time to adequately examine, discuss and give treatment to you.

We will make every effort to accommodate your scheduling needs. In return, we ask you to help us by keeping your scheduled appointments, arriving on time and notifying us a minimum of twenty-four (**24**) hours in advance if you are unable to do so. When we receive advanced notice of cancellation, we are able to avoid lost revenue and misspent employee time, which keeps our overhead down and our fees reasonable. More importantly, we are able to accommodate other patients needing care. Failure to comply with this policy will necessitate the assessment of the following fees:

- Missed appointment without notifying our office at least **24** hours in advance: **A fee of \$20** will be charged to you.
- Second consecutive missed appointment without notifying our office at least **24** hours in advance: Another **fee of \$20** will be charged to you and you will be taken off the schedule to accommodate other patients.

Please sign below that you have read and understand this policy:

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print name:** \_\_\_\_\_