Ultra Spine Care, LLC

2811 Airline Drive,Suite 4, Houston, Texas 77009
Phone: 713-206-4631 * ultraspinecare.com

New Patient Health History Form

Please PRINT Clearly

YOUR INFORMATION

Last Name | **First Name** | **Middle Initial** | **Nickname/AKA**

Date of Birth | **Social Security Number** | **Gender** ☐ **Male** ☐ **Female**

Marital Status ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Life Partner** ☐ **Separated** ☐ **Widowed** ☐ **Other** | **Language** ☐☐**English** **Other:** _____

Occupation | **Employer Name and Address**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Cell Phone**

Email Address

WHAT BRINGS YOU IN TODAY?

Date of onset_____ **Is this from an automobile accident?** ☐**YES** ☐**NO**

PLEASE DESCRIBE INJURY:

_____

Date of injury/ symptoms appeared? _____

Have you ever had this same condition? ☐ **YES** ☐☐ **NO** **If yes, when?** _____

Please list any other providers you have seen for this injury/ condition? _____

Have you ever been under chiropractic care in the past? ☐ **YES** ☐☐ **NO** **If yes, please describe:** _____

Is this condition: Job Related / Auto Related / Home Injury / Fall / Other _____

******* If condition is related to an Auto Accident or Job Injury and will be paid for by Worker's Comp or Auto Insurance, please inform the receptionist immediately in order for you to fill out the appropriate paper work!! *******

INSURANCE (GUARANTOR) INFORMATION

Do you have health insurance? ☐ YES ☐ NO If yes, company name _____

Insurance Address _____

Group# _____ Member# _____

If Automobile accident, provide contact person and CLAIM# _____

EMERGENCY INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ☐ Cell

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YOUR MEDICAL HISTORY

Have you been treated for any conditions in the past year? ☐ YES ☐ NO If yes, please describe _____

Date of last physical exam _____ **Is there a chance you might be pregnant?** ☐ YES ☐ NO
Have you had X-Rays taken? ☐ YES ☐ NO If yes, when and where? _____

What medications are you currently taking, for what condition, and dosage? _____

_____

_____

What vitamins/ minerals/ herbs/ supplements are you currently taking, for what conditions, and dosage?

_____

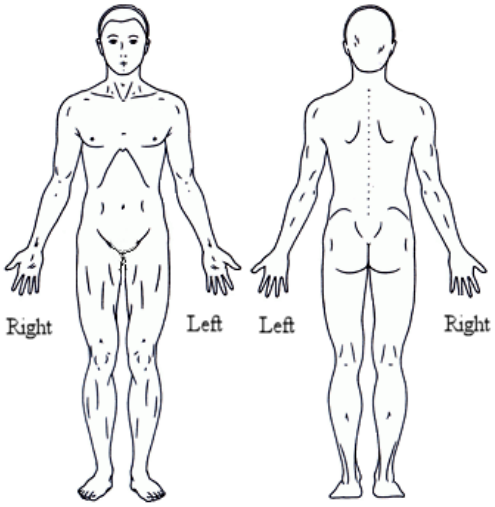
_____

Have you ever:	Yes	No	Briefly explain
Broken Bones?	◇	◇	
Been hospitalized?	◇	◇	
Been in an automobile accident?	◇	◇	
Had sprains/ strains?	◇	◇	
Been struck unconscious?	◇	◇	
Had any surgery?	◇	◇	

FAMILY HISTORY Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	SIBLING(S) Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis					
Allergies, Asthma, or Hay Fever					
Diabetes					
Bursitis					
Cancer					
Back Trouble					
Disc Problems					
Pinched Nerve					
Scoliosis					
Epilepsy					
Headaches/ Migraines					
Heart Disease/ HighBlood Pressure					
Kidney/ LiverTrouble					
Anxiety/ Depression/ Nervousness					
Neuritis/ Neuralgia					
Other:					

YOUR MEDICAL HISTORY (CONTINUED)



Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Numbness	N
Dull Ache	A
Burning	B
Sharp/Stabbing	S
Pins, Needles	P
Other _____	O

What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day? Y/N
Is this condition interfering with
Work?_____ Sleep?_____Routine?_____Other?_____
Is this condition progressively getting worse? Y/ N
Do you wear orthotics? Y/ N
Do changes in weather affect your symptoms? Y / N

HABITS	NONE	LIGHT	MODERATE	HEAVY (AMT)
Alcohol				
Coffee/ Caffeine				
Tobacco				
Recreational Drugs				
Exercise				
Sleep				
Appetite				
Salty Foods				
Sugary Foods				
Soda/ Soft Drinks				
Artificial Sweeteners				
Water				

Please mark any of the following conditions or symptoms that you have now or have experienced:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

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YOUR GOALS AND EXPECTATIONS (circle all that apply)

My goal for consulting with the doctor today:

□ **Temporary Relief from pain and symptoms**	□ **Lasting chiropractic wellness care**	□ **nutritional/ herbal support**
□ **Diet/ Lifestyle improvement**	□ **Weight management**	□ **Detox and purification**
□ **Relief from allergies**	□ **Other (describe)**	□ **Other (describe)**

□**Let doctor recommend best type of care**

I HEREBY ACKNOWLEDGE AND ATTEST TO THE INFORMATION OF THIS FORM AS BEING ACCURATE, COMPLETE, AND UNDEVIATING. THROUGH MY SIGNATURE BELOW I HEREBY GIVE PERMISSION TO THE DOCTOR(S) TO PERFORM THE PROCEDURES WHICH ARE DETERMINED TO BE NECESSARY IN THE DIAGNOSIS AND TREATMENT OF MY CONDITION.

Patient Name (print) _____

Patient Signature_____Date_____

Parent Signature if applicable_____Date_____

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Missed Appointment Policy

Here at Houston Spine Wellness, P.C. we encourage you (patient) to keep appointments designated by the doctor. We understand unforeseen events can occur, so we request that you (patient) call at least 24 hours in advance to cancel or reschedule appointments, allowing appointment availability for other patients requesting to see the doctor. A failed appointment or failure to contact our office at least 24 hours in advance will result in a $25 failed appointment fee.

I _____ have read and understand the missed appointment policy.

Patient Signature Date