New Patient
Medical History Form

Name:_____ **Date of Birth:**_____ **Today's Date:**_____

Reason you are here:_____

Personal Medical History: Have you ever had any of the following conditions? (Check if yes)

☐ Anemia	☐ Crohn's Disease	☐ HIV/ AIDS
☐ Arthritis	☐ Depression	☐ Hypertension
☐ Asthma	☐ Diabetes	☐ Kidney Disease
☐ Cancer	☐ Emphysema	☐ Myocardial Infarction
☐ Chronic Obstructive Pulmonary	☐ Endocrine Problems	☐ Peptic Ulcer Disease
☐ Disease	☐ GERD	☐ Seizures
☐ Clotting Disorder	☐ Glaucoma	☐ Stroke
☐ Congestive Heart Failure	☐ Hepatitis	☐ Ulcerative Colitis

Personal Surgical History: Have you ever had any of the following surgeries? (Check if yes)

☐ Adrenal Gland Surgery	☐ Colon Surgery	☐ Kidney Surgery
☐ Appendectomy	☐ Coronary Artery Bypass Graft	☐ Neck Surgery
☐ Bariatric Surgery	☐ Esophagus Surgery	☐ Prostate Surgery
☐ Bladder Surgery	☐ Gastric Bypass Surgery	☐ Small Intestine Surgery
☐ Breast Surgery	☐ Hemorrhoid Surgery	☐ Spine Surgery
☐ Cesarean Section	☐ Hernia Repair	☐ Stomach Surgery
☐ Cholecystectomy	☐ Hysterectomy	☐ Thyroid Surgery

List names and dates of surgeries: _____

_____

_____

Medications: _____

_____

_____

_____

Allergies: _____

_____

Family History: Has anyone in your family had any of the following conditions? (Check if yes, and indicate relationship to you)

☐ Cancer/Polyps_____	☐ Anemia_____	☐ High Blood Pressure_____
Colon, Rectum, Anal, Stomach, Breast,	☐ Diabetes_____	☐ Anesthesia Reaction _____
Prostate, Uterus, Ovaries, Thyroid, Lung,	☐ Blood Clots_____	☐ Bleeding Problems_____
Blood, Lymphoma	☐ Heart Disease _____	☐ Hepatitis_____
Other _____	☐ Stroke_____	☐ Other_____

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Social History:

Alcohol use - ☐ Never ☐ Occasionally ☐ Daily Type_____

Tobacco use - ☐ Never ☐ Previously, but quit ☐ Packs Per Day_____ for _____ years

Drugs use - ☐ Never ☐ Occasionally ☐ Daily Type_____

What is your occupation?_____

Marital Status: ☐ Single, ☐ Married, ☐ Divorced, ☐ Widowed, ☐ Separated

Name of spouse or significant other _____

Children: Number of Children_____ Number of grandchildren_____

Women: Number of pregnancies_____ , Number of deliveries_____ - Vaginal_____, C-sections_____,

Miscarriages_____, VIPs (abortions) _____

Cancer health habits: (Circle response)

Women				**Men**			
Breast:	Monthly self-exam	Y	N	Prostate:	Yearly rectal exam	Y	N
	Yearly physician exam	Y	N		Yearly PSA blood test	Y	N
	Last mammogram	Y	N				
GYN:	Yearly GYN exam	Y	N				
	Yearly PAP exam	Y	N				
All				Colon:	Yearly rectal exam	Y	N
Skin:	High sun exposure	Y	N		Yearly stool test for blood	Y	N
	Yearly skin exam	Y	N		Date of last colonoscopy _____		

Review of Systems: Do you currently have any of the following symptoms or conditions (Check if yes)

General: ☐ Nothing in this group
- ☐ Weight loss – How much _____lbs
- ☐ Loss of Appetite
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Fainting Spells

Eyes: ☐ Nothing in this group
- ☐ Eye disease or injury
- ☐ Wear glasses or contacts
- ☐ Blurred or double vision

Ear, Nose, Mouth, Throat: ☐ Nothing in this group
- ☐ Hearing loss
- ☐ Ear ache / infection
- ☐ Ringing in ears
- ☐ Nose Bleeds
- ☐ Bleeding gums
- ☐ Mouth sores
- ☐ Sore throat
- ☐ Recent voice change
- ☐ Runny nose / cold
- ☐ Sinus problems
- ☐ Neck stiffness / pain
- ☐ Enlarged neck glands / masses

Cardiovascular: ☐ Nothing in this group
- ☐ Chest pain
- ☐ Palpitations
- ☐ Heart valve problems
- ☐ Calf pain with walking
- ☐ Leg swelling

Respiratory: ☐ Nothing in this group
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Short of breath with activity
- ☐ Short of breath lying flat
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia

Musculoskeletal: ☐ Nothing in this group
- ☐ Joint pain
- ☐ rthritis
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Leg pain with walking
- ☐ Leg pain at rest
- ☐ Broken bones _____

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Digestive: ☐ Nothing in this group
- ☐ Loss of appetite
- ☐ Difficulty swallowing
- ☐ Early satiety (fill up easy)
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Dark, tarry stools
- ☐ Abdominal pain
- ☐ Painful bowel movements
- ☐ Poor control of BMs, urgency

Urinary: ☐ Nothing in this group
- ☐ Burning with urination
- ☐ Weak urine stream
- ☐ Blood in urine
- ☐ Gas or stool in urine
- ☐ Poor control, leakage of urine
- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Testicular mass
- ☐ Get up at night to urinate - Number of times per night ____

Gynecologic (female): ☐ Nothing in this group
- ☐ Irregular periods - Last period:_____
- ☐ Abnormal vaginal discharge

Breast: ☐ Nothing in this group
- ☐ Breast lump
- ☐ Breast pain
- ☐ Nipple discharge

Skin: ☐ Nothing in this group
- ☐ Rash
- ☐ Skin infections
- ☐ Ulcers or sores
- ☐ Yellowing of the skin
- ☐ Eczema, psoriasis, other _____
- ☐ Pyoderma gangrenosum, erythema nodosum

Neurological: ☐ Nothing in this group
- ☐ Frequent headaches
- ☐ Migraines
- ☐ Weakness
- ☐ Seizures
- ☐ Stroke
- ☐ Paralysis
- ☐ Decreased sensation
- ☐ Difficulty with speech
- ☐ Dizziness

Psychiatric: ☐ Nothing in this group
- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings
- ☐ Phobias, fears _____
- ☐ Panic attacks
- ☐ Suicide thoughts or attempts

Endocrine: ☐ Nothing in this group
- ☐ Heat or cold intolerance
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Excessive Sweating

Hematologic, Lymphatic: ☐ Nothing in this group
- ☐ Prior blood transfusion
- ☐ Easy bleeding or bruising
- ☐ Low red blood cell count (anemia)
- ☐ Low white blood cell count
- ☐ Prolonged bleeding with cuts, surgery
- ☐ Swollen glands
- ☐ Blood clots
- ☐ Use of blood thinners
- ☐ Swollen lymph nodes

Allergic, Immunologic: ☐ Nothing in this group
- ☐ HIV infection
- ☐ Hepatitis
- ☐ Imune deficiency
- ☐ Antibiotics needed for dental work

Dr. Sarah Rowden, D.C.
Dr. Josh Rowden, D.C.

www.nwahealthsolutions.com
info@nwahealthsolutions.com

"Beyond Traditional Medicine"
Rogers, AR 72758

F 479.631.0014

5300 S. Southern Hills Ct., Ste 200

P 479.636.1324

INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Parents Signature: _____ **Date:** _____