DR. KATE KEVILLE, DC
HOLISTIC HEALTHCARE
Bringing Every BODY Into Balance

# NEW PATIENT HEALTH HISTORY FORM

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

**TODAY'S DATE:**

| PATIENT DATA | | |
|---|---|---|
| FIRST NAME: | LAST NAME: | DATE OF BIRTH: |
| EMAIL: | MOBILE #: | PHONE 2: |
| May we contact you via e-mail? ☐ YES ☐ NO | Text? ☐ Yes ☐ NO | |
| How did you hear about our practice? | | |

| ADDRESS: | CITY: | STATE: | ZIP CODE: |
|---|---|---|---|
| EMERGENCY CONTACT: | PHONE: | RELATION: | |

| CURRENT COMPLAINTS | | |
|---|---|---|
| DESCRIBE INJURY OR SYMPTOMS: | | |
| DATE OF INJURY OR DATE SYMPTOMS APPEARED: | | |
| HAVE YOU EVER HAD THE SAME CONDITION? ☐ YES ☐ NO | IF YES, WHEN: | |
| DO YOU EXPERIENCE PAIN EVERYDAY? | ☐ NO | ☐ YES |
| DO YOUR SYMPTOMS INTERFERE WITH DAILY LIFE? | ☐ NO | ☐ YES |
| DOES YOUR PAIN WAKE YOU UP AT NIGHT? | ☐ NO | ☐ YES |
| ARE YOUR SYMPTOMS WORSE DURING CERTAIN TIMES OF DAY? | ☐ NO | ☐ YES |
| DO CHANGES IN WEATHER AFFECT YOUR SYMPTOMS? | ☐ NO | ☐ YES |
| WHAT ACTIVITIES AGGRAVATE YOUR SYMPTOMS? | | |

| MEDICAL HISTORY |
|---|
| HAVE YOU BEEN TREATED FOR ANY CONDITION(S) IN THE LAST YEAR? ☐ NO ☐ YES |
| IF YES, PLEASE DESCRIBE: |
| DATE OF LAST PHYSICAL EXAM:<br>IS THERE A CHANCE YOU MIGHT BE PREGNANT? ☐ YES ☐ NO |
| HAVE YOU HAD X-RAYS TAKEN? ☐ YES ☐ NO If YES, where: |
| WHAT MEDICATIONS ARE YOU CURRENTLY TAKING AND FOR WHAT CONDITIONS? (PLEASE LIST DOSAGE AND AMOUNTS) |

**WHAT VITAMINS, MINERALS, SUPPLEMENTS AND/OR HERBS DO YOU CURRENTLY TAKE? (PLEASE LIST ITEM, DOSAGE, FREQUENCY AND FOR WHAT CONDITION(S):**

## FAMILY HISTORY

**Family Members – List present and past health conditions (examples: heart disease, cancer, stroke, diabetes arthritis, etc.)**

| Have you ever: | No | Yes | Briefly Explain: |
|---|---|---|---|
| Had broken bones? | ☐ | ☐ | |
| Been hospitalized? | ☐ | ☐ | |
| Been in an auto accident? | ☐ | ☐ | |
| Had sprains / strains? | ☐ | ☐ | |
| Been struck unconscious? | ☐ | ☐ | |
| Had surgery? | ☐ | ☐ | |
| Had head injury or trauma? | ☐ | ☐ | |
| Received any vaccinations? | ☐ | ☐ | |

| HABITS | NONE | LIGHT | MODERATE | HEAVY |
|---|---|---|---|---|
| ALCOHOL | ☐ | ☐ | ☐ | ☐ |
| COFFEE | ☐ | ☐ | ☐ | ☐ |
| TOBACCO | ☐ | ☐ | ☐ | ☐ |
| DRUGS | ☐ | ☐ | ☐ | ☐ |
| EXERCISE | ☐ | ☐ | ☐ | ☐ |
| SLEEP | ☐ | ☐ | ☐ | ☐ |
| APPETITE | ☐ | ☐ | ☐ | ☐ |
| SOFT DRINKS | ☐ | ☐ | ☐ | ☐ |
| WATER | ☐ | ☐ | ☐ | ☐ |
| SALTY FOODS | ☐ | ☐ | ☐ | ☐ |
| SUGARY FOODS | ☐ | ☐ | ☐ | ☐ |
| ARTIFICIAL SWEETENERS | ☐ | ☐ | ☐ | ☐ |

## SIGNATURES

**PATIENT NAME (PRINTED):** _____

I understand that the Office of Dr. Kate Keville does not file insurance claims. 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 and are due at time of service.

**PATIENT'S SIGNATURE:** _____ **DATE:** _____

**SPOUSE OR GUARDIAN SIGNATURE:** _____ **DATE:** _____

## Have you ever suffered from any of the following?

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Concussion
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or 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 or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other

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

**A**= Acne **O** = Other
**B**=Burning **P**=Pins & Needles
**N**=Numbness **S**=Stabbing