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 or email it to info@leidyholistichealthcare.com. All information is strictly CONFIDENTIAL

PATIENT DATA	TODAY'S DATE:	
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: 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. Jay Leidy 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

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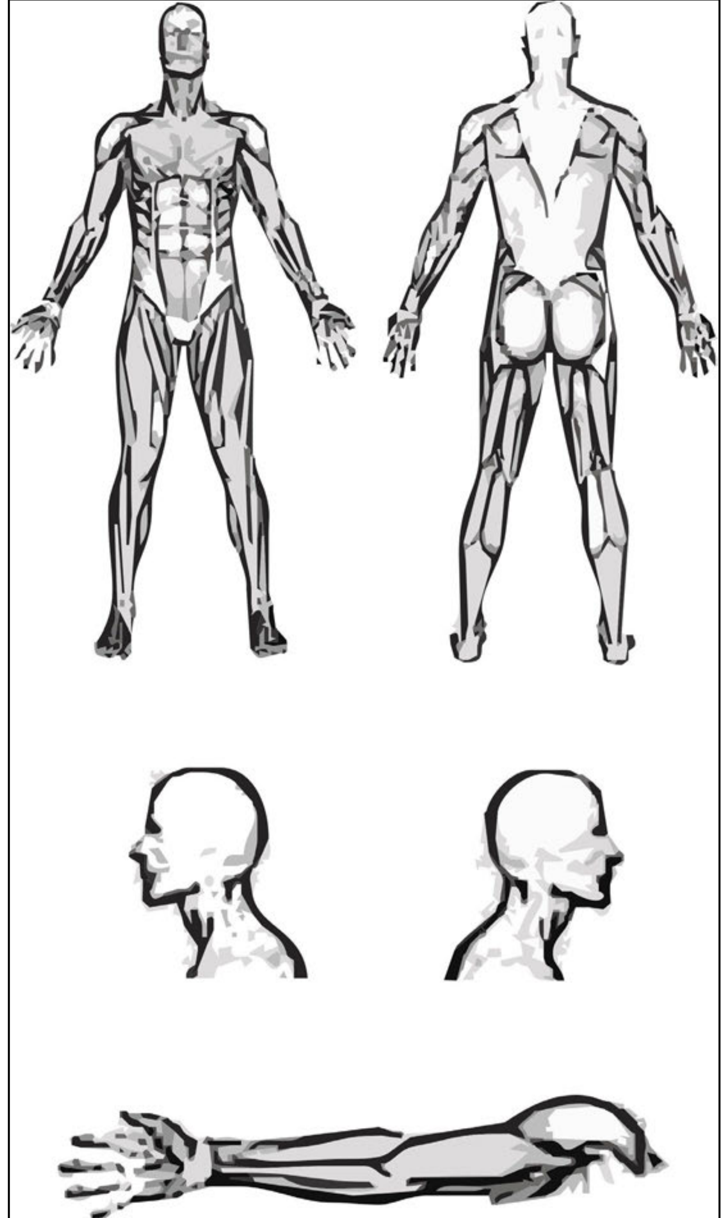

Leidy Chiropractic, LLC

1595 Skylyn Drive – Unit B
Spartanburg, SC 29307

AUTHORIZATION FOR EXAMINATION, REMEDY AND PAYMENT

I, the undersigned, a client in this office, hereby authorize Dr. Jay Leidy (and whomever he may designate as his assistants) to examine me. **Initial Here_______**

Furthermore, I authorize Dr. Jay Leidy to administer remedies as necessary, which may include Chiropractic Adjustments. I hereby certify that I have read and fully understood the above authorization for Examination and Chiropractic Adjustments, the reasons why the above remedies are considered necessary, their advantages and possible complications, if any, as well as possible alternative modes of healing, which were explained to me by Dr. Jay Leidy **Initial Here_______**

I understand that Dr. Jay Leidy may suggest a program of nutritional supplementation as part of the healing process. Analysis of body imbalances are based on muscle testing. It in no way enters into diagnosis of diseases or conditions. These findings only imply that the condition named is an imbalance and not a pathological disease process. Copyright 1990 by Theodore A. Baroody **Initial Here_______**

I authorize Dr. Jay Leidy to evaluate and suggest a healing protocol. I understand that Dr. Jay Leidy does not diagnose or treat any disease. **Initial Here_______**

I understand that some supplements suggested by Dr. Jay Leidy are not evaluated by the FDA and that statements about such supplements are not intended to diagnose, treat, cure or prevent any disease.
Initial Here____

I also certify that no guarantee or assurance has been made as to the results that may be obtained.
Initial Here_____

I understand and agree that only the scheduled patient is allowed in the examination room. If the patient is a minor or requires a Caregiver, accommodations will be made to allow someone other than the patient in the examination room. I understand that Dr. Jay Leidy will not evaluate anyone except the scheduled patient. I understand that if I have questions or concerns about other family patients, that I will follow the protocol explained to me by Dr. Jay Leidy to address. **Initial Here____**

ASSIGNMENT AND AUTHORIZATION

TO: Leidy Holistic Healthcare / Leidy Chiropractic
1595 Skylyn Drive, Unit B
Spartanburg, SC 29307

In consideration of your undertaking to evaluate me, I agree to the following:

1. I hereby attest to the accuracy of my medical and/or accident history and further certify thatI present myself to Dr. Jay Leidy for evaluation and/or remedy of a health-related condition and for no other purpose. I clearly understand that I am totally responsible for payment.
2. I understand that the Office of Dr. Jay Leidy 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.

DATE: ______________________ **PATIENT SIGNATURE:** __________________________________

WITNESS: ___________________ **PRINTED PATIENT NAME:** _______________________________