Jill Marquess, DC

Health History Form

Personal Info

Patient Name: _____ Today's Date: _____

Full Address: _____

Date of Birth: _____ Email: _____

Phone (H): _____ Phone (C): _____ Phone (W): _____

Preferred Method of Contact (circle appropriate): TEXT EMAIL CELL HOME PHONE

Occupation: _____ Primary Care Provider: _____

Do you Live Alone?____ Married?____ Divorced?____ Partnered?____ Kids?____

How Many?____ Ages: ____

Any Known Allergies?_____

Referred By: _____

Emergency Contact

Name: _____ Relationship: _____ Phone Number_____

Current & Past Health History

What is the reason for your visit today? (Wellness, Areas of Concern, Date of Onset and Cause?)

_____

_____

_____

Do you experience numbness, tingling, and/or weakness? If so, where and when?

_____

_____

Do you have a history of Serious Injury?: _____

_____

_____

Do you have a history of Serious Illness?: _____

_____

_____

‹over›

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Health History Form

Current & Past Health History (cont.)

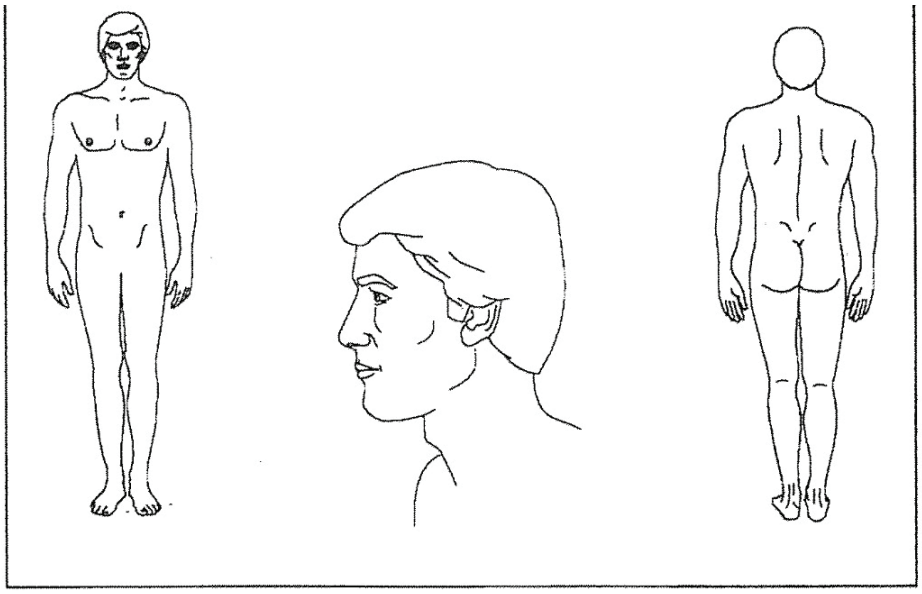
Please list all **hospitalizations and surgeries** (please include dates):

Please list **medications** and what they are for:

Anything else the practitioner should know about you before being treated?

Do you have a goal in being treated today?

Please mark your areas of pain on the figure below



N=Numb
T=Tingle
A=Ache

A Chiropractic Evaluation and Adjustment as well as Myofascial Release, Visceral Manipulation and other soft tissue techniques are considered safe and effective methods of care. Occasionally the patient can have an unfavorable response, such as increased pain or soreness. Before any treatment is performed the practitioner will discuss the treatment plan and get your verbal permission before treatment starts.

Please sign below to give permission for an evaluation.

Print Name: _____

Signature: _____ Date: _____