Patient Health History

Today's Date / / **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____**Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____**Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Continued …

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____
Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

		Start Date			Start Date
1)			**5)**		
2)			**6)**		
3)			**7)**		
4)			**8)**		

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

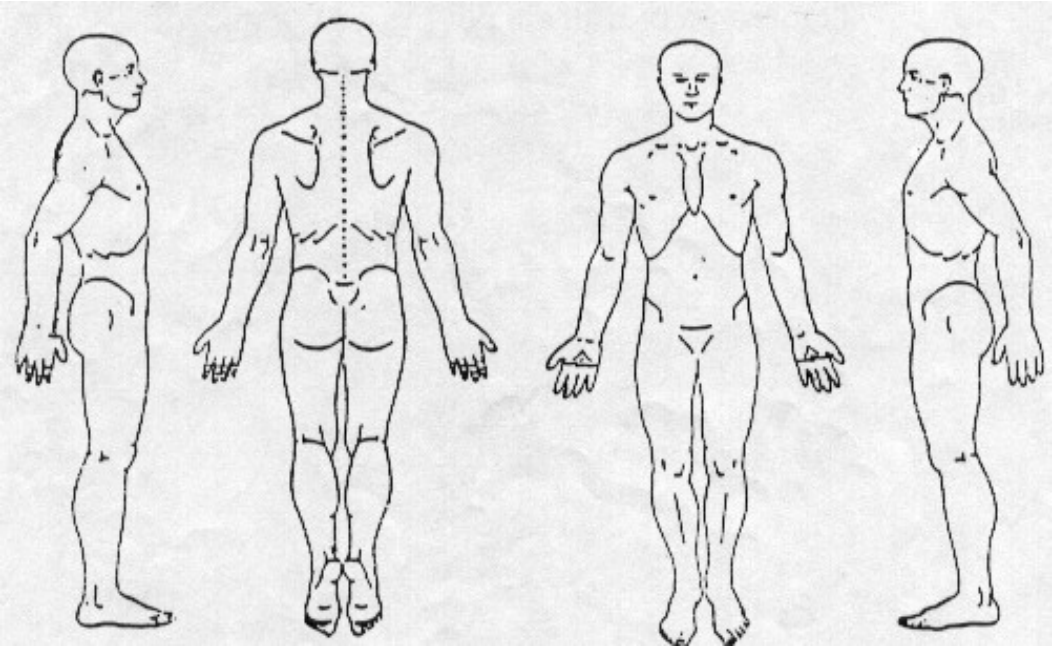
Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____

Pain Diagram

Name_____Today's Date_____Date of Birth___/____/____
Date that your symptoms became worse: ___/____/____
What action(s) may have caused your symptoms_____
_____
What have you done to treat your symptoms_____
_____
On the diagram below, please indicate where you are experiencing pain or other symptoms right now. Please use the numbers from the key below to represent what you feel.



1. Dull	2. Sharp	3. Throb	4. Burn	5. Ache	6. Tingle	7. Cramp	8. Numb	9. Stiff

Please mark the below line with the severity of your discomfort **right now**.

0	1	2	3	4	5	6	7	8	9	10
no pain		mild				moderate				severe pain

Please circle the items that describe your condition.

These aggravate my condition: sit / stand / walk / bend / stoop / lift / sleep / sneeze / cough / reach / twist / look up / look down / movement / rest / typing / house chores / exercise / stairs / lying down

These relieve my condition: sit / stand / lying down / knees up / bracing / movement / no movement / heat / ice / analgesic cream / ibuprofen / medicine / rest / stretch / exercise

_____
Patient Signature

Patient Health History Continued

Employer:
Insurance Co.
Name of Policy Holder: Their DOB:
Policy Number:
Is this injury the result of:
___ an accident ___ an MVA ___ sports ___ work ___ other: _____
IF THIS IS **DUE** TO AN AUTO ACCIDENT OR IS WORK RELATED, **PLEASE LET THE FRONT DESK KNOW.**

Please Mark Any Conditions / Symptoms That You Have

__Abdominal Pain
__ Allergies
__ Anemia
__ Arm Pain
__ Arthritis
__ Asthma
__ Bleeding Disorders
__ Bruise easily
__ Cancer
__ Chest Pain
__ Depression
__ Diabetes
__ Digestive Problems
__ Dizziness
__ Fainting
__ Fatigue
__ Fractures
__Headaches
__ Heart Trouble
__ High Blood Pressure
__ High Cholesterol
__ Kidney Problems
__ Leg Pain
__ Low Blood Pressure
__ Lower Back Pain
__ Loss of Sensation
__ Midback Pain
__ Migraine Headaches
__ Neck Pain
__ Numbness
__ Osteoporosis
__ Palpitations
__ Prostate Disorder
__ Seizures
__ Serious Injuries
__ Sinus Problems
__ Stroke
__ Swollen Joints
__ Thyroid Problems
__ Trauma
__ Tuberculosis
__ Ulcer
__ No problems
Other_____

Please mark if your family has a history of:

__ Cancer
__ Diabetes
__ Heart Trouble
__ High Blood Pressure
Other _____

Signature: _____