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** _____

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

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? ❑ What is your favorite color?

Verification Answer to the Chosen question: _____

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 dosage if known.

If there are no current medications, check here: ❑

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)** _____

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:** _____ / _____

DATE: _____ PATIENT: _____

PATIENT HISTORY

1. What is your **main complaint**? _____
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

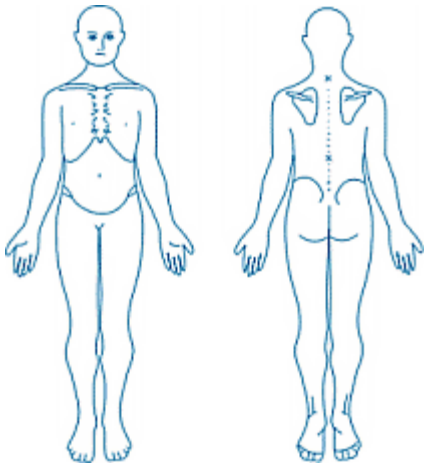
None		***Slight***		***Mild***		***Moderate***			***Severe***
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

3. On the scale below, please **circle** the **percentage of time** you experience your **main complaint:**

	Occasional			***Intermittent***			***Frequent***	***Constant***	
0	**10**	**20**	**30**	**40**	**50**	**60**	**70**	**80**	**90**	**100**

4. How **long** have you been experiencing your **main complaint?** _____
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B**: burning pain **C**: cramping **D**: dull pain **R**: throbbing pain **N**: numbness **T**: tingling



6. When do you notice it most? **AM** **PM**
   How long does it last? _____Min _____Hrs
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? **Y** **N**
10. I have □ been hospitalized □ been treated by another chiropractor
    □ been treated by another specialty provider
    □ never received care for this problem
11. Have you lost time from work because of it? **Y** **N**
12. Are you pregnant? **Y** **N**
13. What was the first day of your last menstrual cycle? _____
14. Number of pregnancies? _____ Miscarriages? _____

Do you have **pain** and/or **difficulty** performing and of the following activities: (Check)

personal care _____
lifting _____
reading _____
concentrating _____
work _____
driving _____
sleeping _____
recreation _____
walking _____
sitting _____
standing _____
social life _____

Signature:

_____

Date: ___/___/___

Name:_____ Date:_____

Systems Review

	Present	Past	No
Cardiovascular:			
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Chest Pain			
High Chrolestrol			
Pace Maker			
Swelling of Legs			
Genitourinary:			
Kidney Disease			
Lower Side Pain			
Burning Urnination			
Frequent Urnination			
Blood in Urination			
Kidney Stones			
Hematologic/ Lymphatic:			
Hepititis			
Blood Clots			
Cancer			
Easy Bruising			
Respiratory:			
Asthma			
Shortmess of Breath			
Emphysema			
Ears/Nose/Throat:			
Drizziness			
Hearing Loss			
Sinus Infection			
Sore Throat			
Difficulty Swallowing			
Psychiatric:			
Depression			

	Present	Past	No
Eyes:			
Glaucoma			
Double Vision			
Blurred Vision			
Integumentary:			
Skin Illness			
Eczema			
Psoriasis			
Rash			
Allergic Immunologic:			
Immune Disorder			
HIV/ AIDS			
Allergy Shots			
Gastrointestinal:			
Digestion Problems			
Bowel Problems			
Liver Problems			
Ulcers			
Bloody Stools			
Musculoskeletal:			
Arthitis			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joint Replaced			
Tension/ Fatigue			
Neurological:			
Stroke			
Seizures			
Head Injury			
Numbness			
Headaches			
Carpal Tunnel			