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 low back spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

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

Problem Areas

Describe your problem:

How did your problem begin:

Onset date of problem: _____

What makes it better or worse? (Times of day, movements, activities):

What have you done to relieve the symptoms: ___ Prescription Medication ___ Over the counter drugs

___ Homeopathic remedies ___ Physical Therapy

___ Surgery ___ Acupuncture ___ Chiropractic

___ Massage ___ Ice ___ Heat _____ Other

What should we know about your current condition:

Personal Medical History

Illnesses

Illness: _____ Illness: _____

Start Date: _____ Start Date: _____

End Date: _____ End Date: _____

Surgeries

Surgery: _____ Surgery: _____

Date: _____ Date: _____

Hospitalizations

Reason: _____ Reason: _____

Date: _____ Date: _____

Duration: _____ Duration: _____

Injuries

Injury: _____ Injury: _____

Date: _____ Date: _____

Family Medical History

Illnesses

Illness: _____ Illness: _____

Relation: _____ Relation: _____

Age of onset: _____ Age of onset: _____

Name of primary care physician: _____

Other Health Care Providers: _____

Review of Body Systems

Musculoskeletal __ No issues

Osteoporosis:	__ Have	__ Had	__ No	Arthritis:	__ Have	__ Had	__ No
Scoliosis:	__ Have	__ Had	__ No	Neck Pain:	__ Have	__ Had	__ No
Back Problems	__ Have	__ Had	__ No	Hip Disorders	__ Have	__ Had	__ No
Knee injuries:	__ Have	__ Had	__ No	Foot/ankle pain:	__ Have	__ Had	__ No
Shoulder Problem:	__ Have	__ Had	__ No	Elbow/Wrist Pain:	__ Have	__ Had	__ No
TMJ Issues:	__ Have	__ Had	__ No	Poor Posture:	__ Have	__ Had	__ No

Neurological __ No issues

Anxiety:	__ Have	__ Had	__ No	Depression:	__ Have	__ Had	__ No
Headaches:	__ Have	__ Had	__ No	Dizziness:	__ Have	__ Had	__ No
Pins & needles:	__ Have	__ Had	__ No	Numbness:	__ Have	__ Had	__ No

Cardiovascular __ No issues

High Blood Pressure:	__ Have	__ Had	__ No	Low Blood Pressure:	__ Have	__ Had	__ No
High cholesterol:	__ Have	__ Had	__ No	Poor circulation:	__ Have	__ Had	__ No
Angina:	__ Have	__ Had	__ No	Excessive bruising:	__ Have	__ Had	__ No

Respiratory __ No issues

Asthma:	__ Have	__ Had	__ No	Apnea:	__ Have	__ Had	__ No
Emphysema:	__ Have	__ Had	__ No	Hay fever:	__ Have	__ Had	__ No
Shortness of breath:	__ Have	__ Had	__ No	Pneumonia:	__ Have	__ Had	__ No

Digestive __ No issues

Anorexia/bulimia:	__ Have	__ Had	__ No	Ulcer:	__ Have	__ Had	__ No
Food sensitivities:	__ Have	__ Had	__ No	Heartburn:	__ Have	__ Had	__ No
Constipation:	__ Have	__ Had	__ No	Diarrhea:	__ Have	__ Had	__ No

Sensory __ No issues

Blurred vision:	__ Have	__ Had	__ No	Ringing in ears:	__ Have	__ Had	__ No
Hearing loss:	__ Have	__ Had	__ No	Chronic ear infection:	__ Have	__ Had	__ No
Loss of smell:	__ Have	__ Had	__ No	Loss of taste:	__ Have	__ Had	__ No

Integumentary __ No issues

Skin cancer:	__ Have	__ Had	__ No	Psoriasis:	__ Have	__ Had	__ No
Eczema:	__ Have	__ Had	__ No	Acne:	__ Have	__ Had	__ No
Hair loss:	__ Have	__ Had	__ No	Rash:	__ Have	__ Had	__ No
					__ Have	__ Had	__ No

Endocrine __ No issues

Thyroid issues:	__ Have	__ Had	__ No	Immune disorders:	__ Have	__ Had	__ No
Hypoglycemia:	__ Have	__ Had	__ No	Frequent infection:	__ Have	__ Had	__ No
Swollen glands:	__ Have	__ Had	__ No	Low enegery:	__ Have	__ Had	__ No

Genitourinary __ No issues

Kidney stones:	__ Have	__ Had	__ No	Infertility:	__ Have	__ Had	__ No
Bedwetting:	__ Have	__ Had	__ No	Prostate issues:	__ Have	__ Had	__ No
Erectile dysfunction:	__ Have	__ Had	__ No	PMS symptoms:	__ Have	__ Had	__ No

Constitutional __ No issues

Fainting:	__ Have	__ Had	__ No	Low libido:	__ Have	__ Had	__ No
Poor appetite:	__ Have	__ Had	__ No	Fatigue:	__ Have	__ Had	__ No
Sudden weight gain/loss:	__ Have	__ Had	__ No	Weakness:	__ Have	__ Had	__ No