## 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:** _____ / _____

**Review of Systems – Are you currently suffering from any of the symptoms listed below?**

- □ General Fatigue
- □ Weakness
- □ Fever (continuous)
- □ Loss of Sleep
- □ Chills (continuous)
- □ Weight Change (unplanned)
- □ Night Sweats
- □ Headaches
- □ Dizziness
- □ Fainting
- □ Convulsions
- □ Nervousness
- □ Anxiety
- □ Depression (prolonged)
- □ Phobias (excessive fears)
- □ Memory Loss or Impairment
- □ Mood Swings (excessive)
- □ Hearing Trouble
- □ Ringing/Pain in Ears
- □ Vision Trouble
- □ Pain in Eyes
- □ Nose/Sinus Pain
- □ Excessive Drainage
- □ Nose Bleeds (chronic)
- □ Nasal Infections (chronic)
- □ Absence of Smell
- □ Mouth Sores
- □ Bleeding Gums
- □ Enlarged Glands
- □ Absence of Taste
- □ Abnormal Taste Sensation
- □ Tonsillitis/Infected Tonsils
- □ Difficulty with Swallowing
- □ Heat/Cold Intolerance
- □ Sugar in Urine
- □ Goiter (enlarged Thyroid gland)
- □ Tremor (shaking)
- □ Skin Rash
- □ Redness Of Skin
- □ Skin Itching
- □ Skin Dryness
- □ Eczema (red, inflamed skin)
- □ Hair Changes (unplanned)
- □ Nail Changes (unplanned)
- □ Bruise Easily
- □ Cough (chronic)
- □ Wheezing (chronic)
- □ Difficulty Breathing
- □ Swollen Extremities
- □ Blue Extremities
- □ Varicosities (visible veins)
- □ Rapid Heart Beat
- □ Chest Pain
- □ Heart Palpitations
- □ Heart Murmur
- □ Decreased Appetite
- □ Increased Appetite
- □ Abdominal Pain
- □ Hemorrhoids
- □ Excess Gas
- □ Vomiting (excessive)
- □ Diarrhea (excessive)
- □ Constipation (excessive)
- □ Heartburn/Indigestion
- □ Painful Urination
- □ Inability to Hold Urine
- □ Frequent Urination
- □ Urinary Retention
- □ Bed-wetting
- □ Irregular Menstruation
- □ Painful Menstruation
- □ Abnormal Vaginal Bleeding
- □ Sterility
- □ Impotence
- □ Lumps in Breast(s)
- □ Redness/Itching of Breast
- □ Dimpling of Breast(s)
- □ Breast Pain
- □ Discharge from Breast(s)

**Habits/Activities – What are your current habits? (Circle One)**

**Caffeinated Drink**…Never <1 glasses/day 2-3 3-4 5+

**Alcohol consumption**…Never <1 glasses/day 2-3 3-4 5+

**Drug/Substance Abuse**… No Yes

**Exercise**… Never <1 days/week 2-3 3-4 5+

**Medical History (Please Answer)**

Have you Ever Been To a Chiropractor? _____

Do You Have A Family Physician? _____

Date of Last Physical Exam: _____

Physicians Name: _____

Have You Been Hospitalized In the Past? _____

Date & Reason for Hospitalization: _____

_____

Have you Ever Had Surgery? _____

Date, Reason, Results of Surgery: _____

_____

Have You Ever Had a Serious Accident/Injury? ___

List Date & Describe Injury: _____

_____

**Family History** – Please Check All that Apply

- □ Cancer
- □ Diabetes
- □ Heart Trouble
- □ High Blood Pressure
- □ Stroke
- □ Kidney Disease
- □ Anemia
- □ Mental Illness
- □ Headaches
- □ Osteoporosis
- □ Arthritis
- □ Joint Problems
- □ Scoliosis
- □ Back Problems
- □ Disc Problems
- □ Congenial Defects
- □ Genetic Disease

**Conditions or Illnesses –** Please Indicate if you Now Have with 'H' or if you Had In the Past with 'P' For Any of The Following Illnesses:

- _ Sinus Trouble
- _ Hay Fever
- _ Allergies
- _ Asthma
- _ Emphysema
- _ Tuberculosis
- _ History of Infection
- _ Fever (Continuous)
- _ Cancer/Tumor
- _ Diabetes
- _ Visual Disturbances
- _ Dizziness/Fainting
- _ Epilepsy/Seizures
- _ Thyroid Trouble
- _ High Blood Pressure
- _ Low Blood Pressure
- _ Heart Trouble
- _ Pacemaker
- _ Stroke (Date:_____)
- _ Aortic Aneurysm
- _ Anemia
- _ Rheumatic Fever
- _ Polio
- _ Multiple Sclerosis
- _ Ulcer
- _ Liver Trouble
- _ Kidney Trouble
- _ Urinary Retention
- _ Prostate Trouble
- _ Arthritis
- _ Osteoporosis
- _ Scoliosis
- _ Dislocated Joints
- _ Spinal Disc Disease
- _ Bone Fracture (List/date_____)
- _ Mental/Emotional Difficulty
- _ Sex. Trans. Disease
- _ HIV
- _ AIDS
- _ Abnormal Weight Gain
- _ Abnormal Weight Loss
- _ Numbness Groin/Buttocks