Patient Health History

Please PRINT clearly.

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First, MI) _____ **Preferred Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Mobile:** _____ **Work:** _____

Email: _____ **Gender:** M / F **Marital Status:** Married / Single / Other

Date of Birth: _____ **Occupation:** _____ **Employer:** _____

Spouse/Significant Other: _____ **Children and Ages:** _____

Are you: Military Veteran / Active Duty Service Member / Reservist / National Guard / ROTC

Referred by *(name)*: _____

☐ **Family** ☐ **Friend** ☐ **Co-Worker** ☐ **Doctor** ☐ **Other:** _____

-CMS requires providers to report both race and ethnicity-

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer **Preferred Language**: _____

Race: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Hawaiian or Pacific Islander / Other / Decline

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ **Preferred Contact Number:** _____

Relationship: Child / Parent / Spouse / Other: _____

Primary Care Physician: _____ **Doctor's Phone:** _____

FINANCIAL INFORMATION -- ***Please allow us to photocopy your insurance card.***

Self Pay (Cash) **Insurance** **Personal Injury/Auto** **Other (please explain)** _____

PRIMARY INSURANCE: _____ **SECONDARY INSURANCE:** _____

Policy Holder: _____ **Policy Holder:** _____

Relation to Insured: Self / Spouse / Parent / Child / Other **Relation to Insured**: Self / Spouse / Parent / Child / Other

Patient Name: _____

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

Major Complaint: _____

When Did It Start (date):_____ **What Event Caused It:**_____

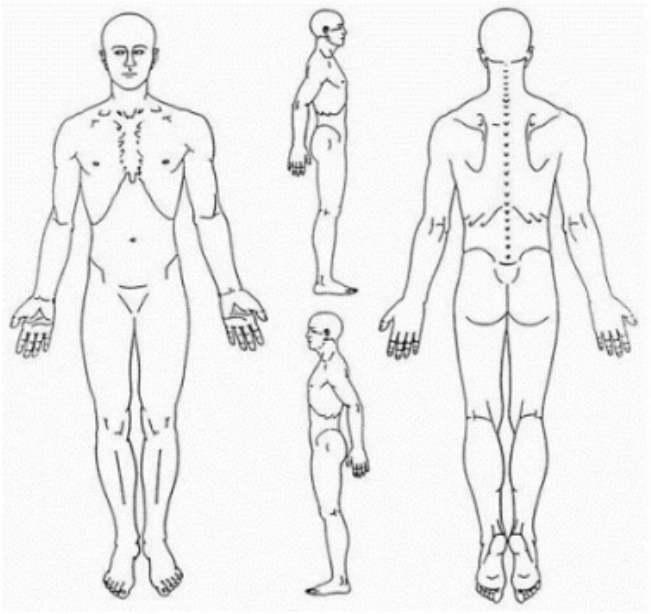
Intensity: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

Is The Complaint: Constant / Off and On

Is The Complaint: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Pins and Needles Other:_____

Does It Radiate/Shoot To Any Areas Of Your Body? No / Yes **If YES, where:**_____

DRAW AREAS OF COMPLAINTS:



What Makes It Better? Ice / Heat / Rest / Movement / Stretching / OTC Meds / RX Meds / Chiropractic

What Makes It Worse? Sit / Stand / Walk / Lying / Sleep / Movement

Who Else Have You Seen For This? No One / DC / MD / PT / Massage / ER / Other:_____

- Where: _____

Diagnostic Tests: None / X-rays / MRI / CT / Other:_____ **When and Where:**_____

Any Other Complaints:_____

Patient Name: _____

Does anyone in your IMMEDIATE family have a history of (circle condition): ☐ **NONE**

Heart Disease If yes, who _____ **Stroke** If yes, who _____

Cancer If yes, who _____ Type_____ **Other Relevant Family History**:_____

PAST HEALTH HISTORY: (List even if it was 20 years ago…)

Injuries, Traumas or Hospitalizations: ☐ **NONE** _____

Surgeries – Date, Type and Reason: ☐ **NONE** _____

Current Medications: *Did you bring a list? Can we make a copy?* ☐ **NONE** _____

Allergies to Medications: *(List and reactions)* ☐ **NONE**

_____

Vitamins & Supplements: *(List all and frequency)* ☐ **NONE**

_____

Are you ***CURRENTLY*** experiencing any of these symptoms? (Check all that apply)

General:
- ❑ Recent Intentional Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ *None in this Category*

Musculoskeletal:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems
- ❑ Leg Problems
- ❑ Broken Bones
- ❑ Muscle Spasms/Cramps
- ❑ *None in this Category*

Neurological:
- ❑ Numbness or Tingling Sensations
- ❑ Loss of Feeling
- ❑ Dizziness or Light Headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or Seizures
- ❑ Have you ever had a head injury?
- ❑ Had an auto accident? Year:_____
- ❑ *None in this Category*

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Blood in Stool
- ❑ Change in Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Constipation
- ❑ *None in this Category*

Cardiovascular & Heart:
- ❑ Chest Pains
- ❑ Rapid or Heartbeat Changes
- ❑ Blood Pressure Problems
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ Heart Problems
- ❑ *None in this Category*

Respiratory:
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Tobacco Use
- ❑ *None in this Category*

Eyes and Vision:
- ❑ Wear Contacts/Glasses
- ❑ Blurred or Double Vision
- ❑ Eye Disease or Injury
- ❑ *None in this Category*

Ears, Nose and Throat:
- ❑ Swollen Glands in Neck
- ❑ Ringing in the Ears
- ❑ Ear-Ache/Ringing/Drainage
- ❑ Sinus/Allergy Problems
- ❑ *None in this Category*

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid Problems
- ❑ Diabetes
- ❑ Cold Extremities
- ❑ Heat or Cold Intolerance
- ❑ Immune System Disorder
- ❑ *None in this Category*

Skin and Breasts:
- ❑ Rash or Itching
- ❑ Non-healing Sores
- ❑ Breast Pain
- ❑ Breast Lump
- ❑ Breast Discharge
- ❑ *None in this Category*

Genitourinary:
- ❑ Kidney Stones
- ❑ Burning/Painful Urination
- ❑ Change in Force/Strain w/Urination
- ❑ Frequent Urination
- ❑ Urinary Leakage or Bed Wetting
- ❑ Blood in Urine
- ❑ *None in this Category*

Women Only:

Are you pregnant?
- ❑ Yes-Due Date: _____
- ❑ No-Last Menstrual Period: _____
- ❑ Painful or Irregular Periods
- ❑ Urine Leakage with Coughing or Sneezing
- ❑ Urine Leakage with Laughing or Lifting
- ❑ *None in this Category*

Pregnancies with Outcome & Date

_____

_____

Other Conditions not listed:_____

Is there anything else you would like the doctor to know? _____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient or Guardian Signature _____ Date_____

Doctor Signature _____ Date _____