PATIENT HEALTH HISTORY

Today's Date: ________________

PATIENT INFORMATION

Name (Last, First, Middle) :____
Address:________________________________ City:____________________ State: ______ Zip:___________
E-mail Address: ____ Date of Birth: ___________Gender: M / F
Age _______ Marital Status: Married / Single / Other SS# _____________________________

Cell Phone: (_____) _______________________ Home Phone (_____)_____________________
Work Phone: (_____) _______________________ Best Contact Number (_____) ____________________
Name of Employer ______________________________ Occupation: ___________________________________

*Referred by: ____

EMERGENCY CONTACT INFORMATION

Full Name:____ Relationship: Child / Parent / Spouse / Other
Phone Number: (_____) ______________________ Primary Care Physician:_____________________________

FINANCIAL INFORMATION

☐ Insurance ☐No Fault ☐Self-Pay (Cash)

PRIMARY INSURANCE:
Name: ___________________________________
Relationship: Self / Spouse / Parent / Child / Other
(Other than Self)
Insured Name: ____________________________

SECONDARY INSURANCE:
Name: ______________________________________
Relationship: Self / Spouse / Parent / Child / Other
(Other than Self)
Insured Name: _________________________________

Address:________________________________ City:____________________ State: ______ Zip:___________

HISTORY OF CURRENT CONDITION

Describe Major Complaint: ____
Began When? _______________________
Describe how this began:
____
____
Severity of the complaint: Mild / Moderate / Severe / Very Severe
Quality of pain: Sharp / Stabbing / Burning / Aching / Dull / Stiff & Sore / Other
How frequent is the complaint present? Off & On / Constant

*Does the complaint travel to another area of the body? No / Yes (Describe) _______________________
Head- Base of Skull / Forehead / Temple R / L Both ***Leg-*** Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both
Arm- Across Shoulder / Elbow / Hands-Fingers R / L / Both ***Other Area-*** _____________________________

What makes symptoms better? Ice / Heat / Rest / Movement / Stretching / OTC / Other:___________________

What makes symptoms worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: ______________________

Which daily activities are being affected by this condition? ____

<u>For this CURRENT condition, have you:</u>

- Received any other treatment? None / DC / MD / PT / Massage / ER / Other: _____________________
  Where? _______________________________________
- Had any previous surgery or intervention in this area? (Describe) _______________________________
- Taken any medication? OTC / Prescriptions ____
- Had any diagnostic testing? X-Rays / MRI / CT / Other: __________________
  When and Where? ______________________________

Describe any **SECONDARY** complaints: ____

HEALTH HISTORY

Current Medications: *NONE* (List): _____________
(*Have a list? We can make a copy*)________________
____
____
____
____
____
____

Family Health History: (Please mark N/A if irrelevant)
List relevant major health issues of immediate relatives
____
____
____

Deaths in immediate family: (Cause and at what age?)
____
____

Past Health History: (Please list any past…..)
Surgeries – Date, Type and Reason: *NONE*
____
____
____
____

Social & Occupational History:
(Hobbies, recreation, exercise, diet, work, vitamins)
____
____
____
____

Major Injuries / Treatment: *NONE*
____
____
____
____

Major Hospitalizations: *NONE*
____
____
____
____

Habits:
Cigarettes – (#/day): ___________________________
Alcohol – (amount/day): ________________________
Coffee/Tea – (cups/day): ________________________
Rec. Drugs – (List): ____________________________

REVIEW OF SYSTEMS

0 = NEVER HAD 1 = CURRENTLY HAVE 2 = PREVIOUSLY HAD

GENERAL	**MUSCULOSKELETAL**	**NEUROLOGICAL**
Recent weight gain	Arthritis	Lightheaded/Dizzy
Recent weight Loss	Rheumatoid Arthritis	Memory Loss
Fatigue	Broken Bones	Headaches
Fever	Osteoporosis/Osteopenia	Migraines
Allergies	Gout	Numbness
Loss of appetite	Scoliosis	Weakness
Chills	Spinal Trauma	Stroke
Cancer of Any Kind	Joint Pain (anywhere)	Tingling/Numbness
	Cramping of muscles	Fainting episodes
CARDIOVASCULAR	**RESPIRATORY**	**SKIN**
Heart Attack	Coughing	Bruise Easily
Swelling of Ankles	Coughing Up Blood	Skin Rashes
High Blood Pressure	Chronic Cough	Discolorations
Low Blood Pressure	Chest Pain	Psoriasis
Shortness of Breath	Asthma	Changes in Moles
Pain Down Left Arm	Pneumonia	Sores
Profuse sweating	Bronchitis	Scars
High Cholesterol	Tuberculosis	Itching
EYES, EARS NOSE &	**GASTROINTESTINAL**	**GENITOURINARY**
Blurred Vision	Gall Bladder Problems	Painful Urination
Double Vision	Liver Problems	Blood in Urine
Ear pain	Pain over Stomach	Frequent Urination
Hoarseness	Ulcers	Kidney Infection
Nose Bleeds	Colitis	Kidney Stones
Glaucoma	Hiatal Hernia	Incontinence
Dental problems	Blood in Stool	

Women **ONLY**:
Are you Pregnant? YES / NO (If yes) Due Date: _______________

Additional Concerns/Comments:

____

____

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 these states statutes.

Patient or Guardian Signature: ____ Date: _________________

Treating Doctor Signature: ____ Date: _________________