Patient Health History

Today's Date____________________

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___________________________ Work Phone_________________________________

Home Email____

Work Email____

Contact Method (check one)

❑ Primary phone ❑ Secondary phone ❑ Mobile phone ❑ Work 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 ❑ American Indian/Alaskan Native
❑ Asian ❑ Native Hawaiian or other Pacific Island ❑ 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 ____

Verification Question (choose only one question, then give the answer to the 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 favorite color? ❑ What street did you grow up on?
❑ What was the make of your first car? ❑ When is your anniversary?

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?

No interest ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 Very interested

Current medications, including frequency and 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)____

2)____ 4)____

Briefly list your main health problems and reason for visit today:

____

____

Date of accident/first symptom______________________________

Is your condition due to: ❑ Automobile accident ❑ Personal injury ❑ Job injury ❑ Other____________

Please circle the number that best describes your pain: No pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

What is the nature of your symptoms? ❑-Dull ❑-Sharp ❑-Throbbing ❑-Burning

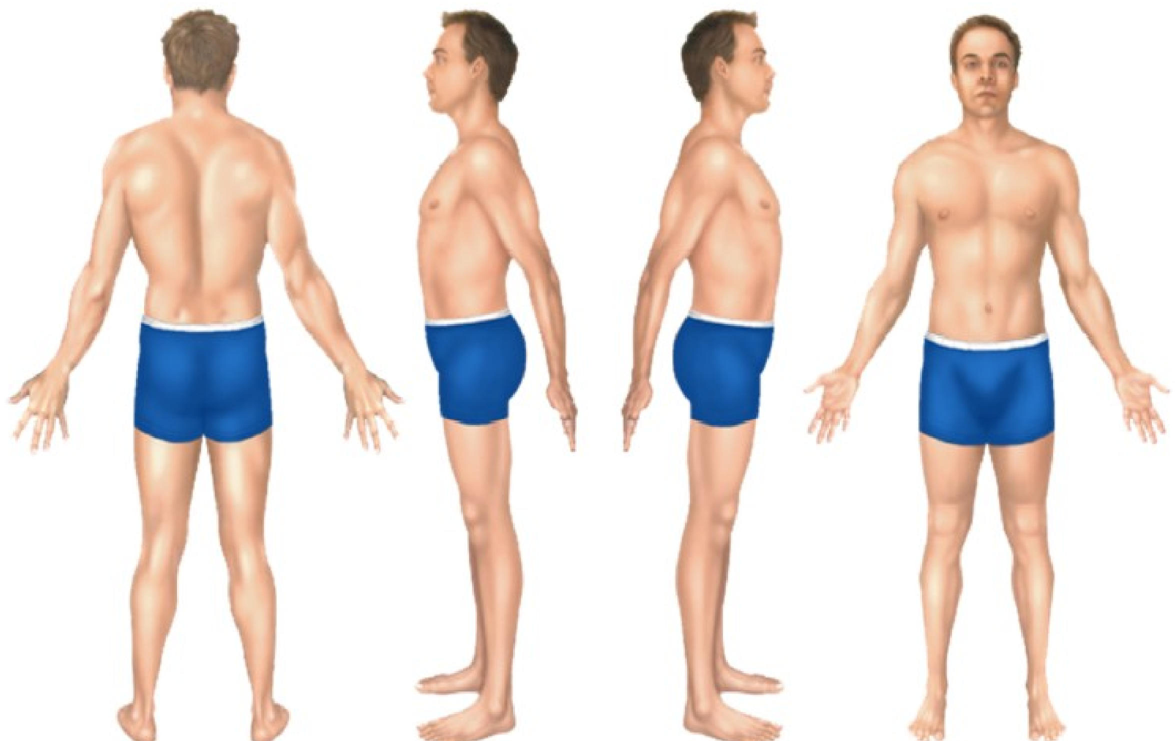
❑-Deep ❑-Aching ❑ -Tingling ❑-Stabbing ❑-Cramping ❑-Numbness ❑-Radiating

What have you done to relieve the symptoms: ____

____

What makes it worse: ____

Location of symptoms:



Have you been in an automobile accident? (date and describe impact)

____

Have you had previous falls or other injuries? (date and describe)

____

Have you been previously hospitalized and/or had any surgeries? (date and describe)

____

Has any doctor diagnosed you with Hypertension/ High Blood Pressure 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:*____

Height: _____Ft ______In **Weight**: ____________ pounds **Blood Pressure**: _________ / ________

Family History: Please indicate Mother, Father, Sister, Brother, Daughter, Son

__________No Known Conditions __________Cancer __________Clotting Disorder

__________Dementia/ Alzheimer's __________Diabetes/ Pre-Diabetes/ Metabolic Syndrome

__________Heart Disease __________High Cholesterol __________Hypertension

__________Kidney Disease __________Lung Disease __________Osteoporosis

__________Stroke/ Brain Attack __________Unknown Disease

Other ____

What are your habits?

1. Alcohol	Never	Occasionally	Frequently	Constantly
2. Soda	Never	Occasionally	Frequently	Constantly
3. Coffee	Never	Occasionally	Frequently	Constantly
4. Water Consumption	Never	Occasionally	Frequently	Constantly
5. Exercise	Never	Occasionally	Frequently	Constantly
6. Pain reliever frequency	Never	Occasionally	Frequently	Constantly

How did you hear about our office?

❑ Phone Book ❑ Online ❑ Sign ❑ Other_______________________________

❑ Referral_____________________________

Person responsible for payment:

____

Acknowledgements

Chiropractic care:

I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Privacy Verification:

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Permission to contact:

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Payment Verification:

I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

X-ray Verification:

(females only)
I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant or I understand the risks.
Date of last menstrual period:

General Verification:

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

______________________________ ______________________________

Patient/Guardian Signature **Date**