Patient Health History

Patient title: *(check one)* ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Prof. ☐ Rev. **Parent/Guardian**_____

First Name_____ **Middle Name**_____ **Last Name**_____ **Suffix**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Primary Phone #_____ **Secondary Phone #**_____

Email Address_____

****New federal regulations require us to email you your health information. By providing my email address, I authorize my doctor to contact me regarding my health records.*

Contact Method: *(check one)* ☐ Primary Phone ☐ Secondary Phone ☐ Email Address **Driver Lic. #**_____

Gender ☐ Male ☐ Female **Date of Birth**_____ **Age**_____ **SS#**_____

Employment Status: ☐ Employed ☐ Student ☐ Retired ☐ Unemployed **Occupation**_____

Employer_____ **Marital Status:** ☐ S ☐ M ☐ D ☐ W

Number of Children_____ **Spouse's Name**_____

Spouse's Occupation_____ **Spouse's Employer**_____

Race: *(check one)* ☐ White ☐ Black/African American ☐ Hispanic ☐ Other_____ **Multi-Racial:** ☐ Yes ☐ No ☐ Unknown

Preferred Language: ☐ English ☐ Spanish ☐ Other_____ **Referred by**_____

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐ Never been a smoker

If yes, how often do you smoke? ☐ Current everyday 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 include mg, mcg, etc. (dosage). If **no current medications, check here:** ☐

1. _____ Dosage_____ 4. _____ Dosage_____
2. _____ Dosage_____ 5. _____ Dosage_____
3. _____ Dosage_____ 6. _____ Dosage_____

List any known allergies you have had to any medications. If no medication allergies are known, check here: ☐

1. _____ 2. _____

X-rays *(within the last yr)*_____ **Facility taken at**_____

MRI/CAT Scan *(within the last yr)*_____ **Facility taken at**_____

OTHER DOCTORS SEEN FOR THIS CONDITION? ☐ Yes ☐ No **If yes** *(check one)* ☐ **MD** ☐ **DC** ☐ **DO** ☐_____

Doctor's name_____ **Diagnosis**_____**Treatment**_____

Were you taken off work? ☐ Yes ☐ No **Have you returned to work?** ☐ Yes ☐ No **If no, why?**_____

Is this condition due to a work, auto, or personal (slip & fall) injury? ☐ Yes ☐ No **-If yes, do you have an open claim?** ☐ Yes ☐ No

Have you been diagnosed with Diabetes? ☐ Yes ☐ No **--If yes what type?** ☐ Type 1- Juvenile ☐ Type 2- Adult Onset ☐ Gestational

List any other health conditions you are currently under medical care for *(ex: Asthma, High Blood Pressure, Colitis)* _____

_____

Security verification Question *(choose only one question by checking next to it, and then give the answer to that question below)*

☐ 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 you mother's maiden name? ☐ On what street did you grow up?

Security verification Answer to the chosen question:_____

Answer must be at least 6 characters

I clearly understand and agree that all services rendered to me are charged to me and that I am personally responsible for payment. If filing a claim through any third party and the claim or treatment is not allowed, I agree that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.

Patient or Parent/Guardian Signature_____ **Date** _____

Please list your area of complaint & indicate which side of the body the pain is located on:

1. _____Right/Left/Both
2. _____Right/Left/Both
3. _____Right/Left/Both
4. _____Right/Left/Both
5. _____Right/Left/Both
6. _____Right/Left/Both

How long have you had this condition? _____

What caused your painful symptoms to begin? _____

Is this condition *(ONLY CHECK ONE)* □ **better or** □ **worse (in the)** □ **morning** □ **mid-day** □ **end of the day** □ **night**

Does the pain travel anywhere? □ Yes □ No **If yes, where?** _____

DO NOT WRITE BELOW - FOR OFFICE USE ONLY:

NOTES:

_____

_____

Symptoms that explain how the pain feels:

_____dull	_____sharp	_____sharp w/ movement	_____throbbing
_____burning	_____deep	_____aching	_____tingling
_____stabbing	_____cramping	_____pinprick	_____numbness
_____radiating	_____tightness	_____stinging	_____soreness
_____pinching	_____tender	_____pulling	_____stiffness
_____tense	_____ouchy	_____grabbing	_____knots
_____nauseating	_____shoots to front	_____ "just hurts"	_____weakness
_____nagging	_____ "pops"	_____jabbing	_____ "catches"
_____nasty	_____electric shock	_____gnawing	_____crummy
_____crackles	_____shooting	_____squeezing	_____cracks
_____with movement	_____twinges	_____tiredness	_____ "kink"
_____ "buzzing"	_____grinding	_____spasm	_____sore
_____ cramping	_____mild pain/soreness	_____feel pressure	_____just a tinge
_____ discomfort	_____		

Factors that increase symptoms:

_____sitting	_____standing	_____walking	_____bending
_____stooping	_____lifting	_____sleeping	_____sneezing
_____coughing	_____straining	_____reaching	_____twisting
_____looking up	_____looking down	_____general movement	_____rest
_____lying on back	_____driving	_____typing on a computer	_____scooping
_____house chores	_____exercise	_____stair stepping	_____working
_____rotating head left	_____rising from seat	_____cutting grass	_____computer work
_____cleaning	_____side sleeping	_____baking	_____sweeping
_____washing dishes	_____turning head right	_____yard work	_____general activities
_____extension	_____changing position	_____raising right arm	_____laying/left side
_____when tired	_____swimming	_____laughing	_____picking up kids
_____raking leaves	_____grading papers	_____carrying groceries	_____mopping
_____carrying laundry	_____vibration	_____being touched	_____golfing
_____laying/right side	_____traveling	_____being tired	_____shoveling snow
_____carrying purse/luggage	_____sitting crooked	_____chewing	_____football
_____raising both arms	_____making bed	_____vacuuming	_____folding laundry
_____lights	_____laying down	_____raising left arm	_____going down stairs
_____pushing	_____quick movement	_____	

Factors that relieve symptoms:

_____sitting	_____standing	_____lying down	_____knees bent up
_____leaning for support	_____no movement	_____movement occurs	_____heat applied
_____applying ice	_____pain relief gel	_____medication used	_____rest
_____stretching/exercise	_____adjustment provided	_____turning/other side	_____sitting with pillows
_____massage	_____laying/right side	_____walking	_____bending
_____laying/left side	_____straightening legs	_____soaking in a bath	_____blankets over window
_____elevating leg	_____taking hot shower	_____bending forward	_____propping feet up

_____