CONFIDENTIAL 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:** _____ **SS Number:**_____

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

We are a referral practice and as such, we like to thank those who refer to us.

Who referred you to our practice? _____

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 scan your insurance card.***

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

PRIMARY INSURANCE: _____

Policy Holder: _____

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

Patient Name: _____

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

Major Complaint: _____

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

If this is NOT the first time, how long has this been a recurring problem? _____

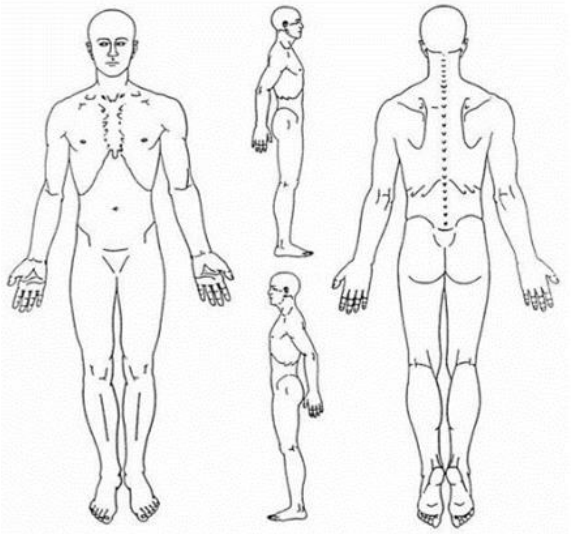
Intensity: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

The Complaint is: Constant / Comes and Goes

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 Unintentional 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
- ❑ Dizziness or Lightheaded
- ❑ Weakness
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or Seizures
- ❑ Have you ever had a head injury?
- ❑ Had an auto accident? Year:_____
- ❑ *None in this Category*

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

Eyes and Vision:
- ❑ Blurred or Double Vision
- ❑ *None in this Category*

Ears, Nose and Throat:
- ❑ Ringing in the Ears
- ❑ Earache/Ringing/Drainage
- ❑ Sinus/Allergy Problems
- ❑ *None in this Category*

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

Gastrointestinal:
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid Problems
- ❑ Diabetes
- ❑ Immune System Disorder
- ❑ *None in this Category*

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

Genitourinary:
- ❑ Kidney Stones
- ❑ Burning/Painful Urination/Blood in Urine
- ❑ Bed Wetting
- ❑ *None in this Category*

Women Only:

Are you pregnant?
- ❑ Pregnant Due Date: _____
- ❑ No-Last Menstrual Period: _____
- ❑ Painful or Irregular Periods
- ❑ *None in this Category*

Pregnancies with Outcome & Date

_____

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.

Patient or Guardian Signature _____ Date_____

Doctor Signature _____ Date _____