Patient Health History

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____ **Work Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email addresses provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Who can we thank for referring you to our office?_____

Contact Method *(check one)* ❑ Primary Phone ❑ Secondary Phone ❑ Mobile 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 ❑ Student ❑ Self Employed ❑ Retired ❑ Other

Race *(check one)* ❑ White ❑ Black/African American ❑ Hispanic ❑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 *(check one)* ❑ English ❑ Spanish ❑Other_____ ❑ I choose not to specify

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?
❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

1)_____ **2)**_____ **3)**_____

4)_____ **5)**_____ **6**_____

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

1) _____ **2)**_____ **3)**_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

Reason for today's visit: ❑New Injury ❑Old Injury ❑Chronic Pain ❑Wellness
Are you in pain: ❑Yes ❑No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense
Did your injury occur during: ❑Work ❑Sports/Play ❑Auto Accident ❑Routine/Household activity

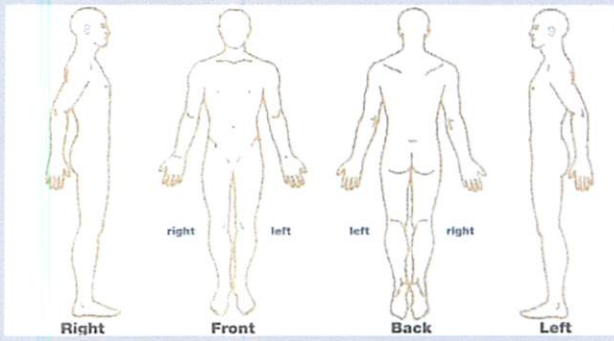
When did your condition/accident occur? _____/_____/_____ Where did your injury occur? _____

Please explain what happened: _____
Is your condition getting worse? ❑Yes ❑No ❑Constant ❑Comes and goes.
Is your condition interfering with your: ❑Work ❑Sleep or Daily routine? If so, how: _____

_____

Has this or something similar happened in the past? ❑Yes ❑No
Explain:_____

Using the adjacent body charts, please circle all affected areas.
Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where? _____
_____



Are you taking any of the following medications? ❑Nerve pills
❑Pain killers (including aspirin) ❑Muscle relaxers ❑Blood Thinners
❑Tranquilizers ❑Insulin ❑Other
_____

Do you have or have you had any of the following diseases, medical conditions or procedures?

❑Glaucoma	❑Heart Attack/Stroke	❑Heart Surg./Pacemaker	❑Heart Murmur
❑ Congenital Heart Defect	❑Difficulty Breathing	❑Artificial Valves	❑Alcohol/Drug Abuse
❑Venereal Disease	❑Mitral Valve Prolapse	❑HIV+/AIDs/ARC	❑Shingles
❑High/Low Blood Pressure	❑Frequent Neck Pain	❑Anemia/Diabetes	❑Cancer
❑Psychiatric Problems	❑Rheumatic Fever	❑ Kidney Problems	❑Hepatitis
❑Ulcers/Colitis	❑Fainting Seizures/Epilepsy	❑Sinus Problems	❑Emphysema/Asthma
❑Tuberculosis	❑Severe/Frequent Headaches	❑Chemotherapy	❑Lower Back Problems
❑Arthritis	❑Artificial Bones/Joints/Implants		

Please list any surgeries with dates and /or any other serious medical condition(s) not listed above: _____

_____

List any past serious accidents with dates: _____

Do you exercise? ❑No ❑Yes_____ hours per week. Are you wearing: Shoe lifts ❑Inner soles ❑Arch supports
Are you dieting ❑No ❑Yes Since _____/_____/_____
For Women: Are you taking Birth Control? ❑Yes ❑No
Are you Nursing? ❑Yes ❑No If so, how many weeks? _____

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____Date_____/_____/_____
❑Adult Patient ❑Parent or Guardian ❑Spouse

To be performed by clinic Staff: Height: _____inches Weight _____pounds BP: _____/_____

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