

Patient Health History

Today's Date

Signature of Patient _____

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

First Name _____

First

MI

Last

Nick Name _____

Suffix _____

Address 1 _____

City _____

State _____

Zip Code _____

Primary Phone _____

Secondary Phone _____

Email _____

By providing my email address, I authorize the office to contact me via the email for Clinic Updates, Announcements & Birthday Cards.

Patient Identification:

Date of Birth: / /

Age _____

Gender (check one)

Male

Female

Unspecified

Patient SSN _____

Marital Status (check one)

Single

Married

Other

Spouse Name: _____

Employment Status: (check one)

Employed

FT Student

PT Student

Other

Retired

Self Employed

Employer Name: _____

Phone: _____

Insured Data Policy Holder: (check one)

Self

Spouse

Parent

Other

Employee

Insured Name: _____

Date of Birth

/ /

Emergency Contact

Name: _____

Phone: _____

Relation (check one)

Spouse

Sibling

Parent

Friend

Employee

Race (check one)

White

Black/African American

Hispanic

American Indian/Alaskan Native

Asian

Asian Indian

Chinese

Filipino

Native Hawaiian or other Pacific Island

Other _____

I choose not to specify

Ethnicity (check one)

Hispanic or Latino

Not Hispanic or Latino

I choose not to specify

How did you hear about our office? Whom may we thank for your referral? (check one)

Family Member*

Living Social

Internet Web Site

Google

Attorney*

ValPak

Groupon

Yahoo

Friend*

Direct Mail

Sign on Building

Bing

Physician*

Dex

Yellow Book

Other

* Please Describe _____

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:

	Start Date		Start Date
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) _____

Current health problems:

Has any doctor diagnosed you with Hypertension 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: _____

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

Have you ever seen a Chiropractor, M.D. or D.O. for Spinal Manipulation before? Yes No

Have you ever had Acupuncture before? Yes No

Have you ever had Physical Therapy or Rehabilitation before? Yes No

Reason for visit today (primary complaint):

When did your symptoms start?

/ /

How did your symptoms begin? Auto Injury Work Injury Slip or Fall Sports Injury Lifting Prolonged Driving Excessive Standing/Walking Repetitive Motion Reaching Vacuuming Sitting at Computer Household Chores Lawn work Shoveling Violent Sneeze or Cough Other _____ Unknown

How often do you experience your symptoms throughout the day?

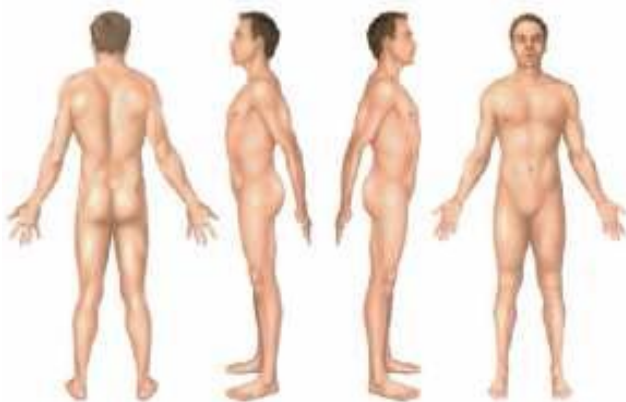
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Rate your intensity of pain for the region of complaint: (0= No Pain 5 = Moderate 10 = Unbearable)

0 1 2 3 4 5 6 7 8 9 10

Additional Complaints: 2. _____ 3. _____
4. _____ 5. _____

By using the diagram below, please indicate on the body where you are experiencing your symptoms:



What describes the nature of your symptoms:

Dull Sharp Throbbing Burning Tingling Stabbing Cramping Numbness Radiating Other _____

How are your symptoms changing throughout the day?

Getting Better Same Getting Worse

Does your pain wake you up at night? Yes No

Does your pain travel or radiate from one part of your body to the other? Yes No (if Yes please indicate on diagram)

Have you applied Ice to the affected area? Yes No *If Yes did the condition get: Better Worse Same

Have you applied Heat to the affected area? Yes No *If Yes did the condition get: Better Worse Same

Have you seen anyone else for this condition? Yes No *If Yes Whom: _____

Additional information may be provided in the space below:

Empty rectangular box for additional information.