Patient Health History

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

First Name_____ **Nick Name**_____

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

Address_____

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

Social Security No. _____**Home Phone** _____

Mobile Phone _____ **Work Phone**_____

Home email _____
*****Your e-mail address will not be used for Spam but will allow you access to an online portal to view your records and allow us to communicate to you personalized health information.***

Contact Method *(check one)*

❑ Primary Phone ❑ Mobile Phone ❑ Work Phone

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other

Employer_____ **Occupation**_____

Employment Status ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Spouse's Name_____ **Spouse's Employer**_____

Emergency Contact Name & Number_____

Names and Ages of Your Children_____

How were you referred to our office? _____

Race ***(check one)***

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑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	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Verification Question ***(Choose only one question by checking the question, then give the answer to that 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 mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____
****Answers must be at least 6 characters****

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 medication allergies. If no known allergies, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: _____

_____

Date of Injury: _____ **Date Symptoms First Appeared:** _____

Have you ever had the same condition: ❑ Yes ❑ No If yes, when? _____

List other practitioners seen for this injury/condition: _____

Have you had chiropractic care? ❑ Yes ❑ No **Please describe:** _____

_____

What is the name of your family physician? _____

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: _____

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*

Have you had an X-ray, CT scan or MRI in the past six years ? ❑ Yes ❑ No

If yes, where and when: _____

Have you have had surgery or been hospitalized? List with dates*:* _____

_____

List any automobile accidents or injuries _____

_____

List any fractures or dislocations _____

Social History/Habits:

Sleep _____hours Coffee/Tea _____cups/day Alcohol _____drinks/week Soda _____drinks/day

Water _____glasses/day Exercise _____/week Recreational Drug Use: ____None ____Past ____Present

Physical Stress Level: _____Mild _____Moderate _____High

Emotional Stress Level: _____Mild _____Moderate _____High

Family History:

	Arthritis	Cancer	Diabetes	Heart disease	High blood pressure	Stroke	Psychiatric	Other
Father								
Mother								
Brothers								
Sisters								
Sons								
Daughters								

Recreational Activities:

_____backpacking _____biking _____bowling _____gardening _____golf _____racquetball _____running

_____tennis _____walking _____hunting _____fishing Other _____

INSURANCE

IF YOU HAVE MADE PRIOR FINANCIAL ARRANGEMENTS WITH OUR OFFICE THE FOLLOWING PARAGRAPH WILL NOT APPLY TO YOU.

This Office is a participating provider with several insurance companies. For the companies that we do not participate with there may be out of network benefits that would cover all or part of your services. This Office will make every possible effort to verify your benefits prior to proceeding with any services. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Check type of Insurance coverage:

❑ Workman's Compensation ❑ Automobile Insurance Policy ❑Company Health Plan ❑ Group Policy

❑ Personal Policy ❑ Other

_____

Patient's Signature

Date: _____

_____

Guardian's Signature

To be performed by clinic staff:

Height: _____inches **Weight:** _____pounds **BMI:** _____ **BP:** _____/_____ **Pulse:** _____