# 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:** _____ **Employer:**_____

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

**Are you:** Military Veteran / Active Duty Service Member / Reservist / National Guard / ROTC

**Referred by** *(name)*: _____

☐ **Family** ☐ **Friend** ☐ **Co-Worker** ☐ **Doctor** ☐ **Other:**_____

***-CMS requires providers to report both race and ethnicity-***

**Ethnicity**: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer **Preferred Language**:_____

**Race**: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Hawaiian or Pacific Islander / Other / Decline

**Smoking Status**: Every Day / Some Days / Former / Never

## 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 photocopy your insurance card.***

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

**PRIMARY INSURANCE**: _____ **SECONDARY INSURANCE**:_____

**Policy Holder**: _____ **Policy Holder**:_____

**Relation to Insured**: Self / Spouse / Parent / Child / Other **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?** _____

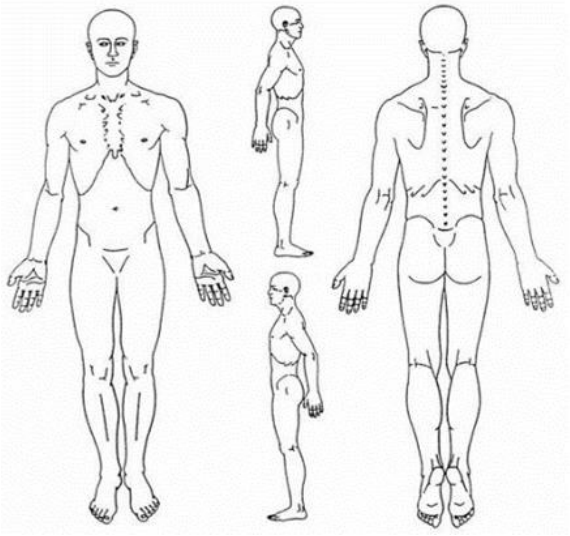
**Intensity:** None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

**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 Intentional 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
- ❑ Loss of Feeling
- ❑ Dizziness or Light Headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or Seizures
- ❑ Have you ever had a head injury?
- ❑ Had an auto accident? Year:_____
- ❑ *None in this Category*

**Gastrointestinal:**
- ❑ Loss of Appetite
- ❑ Blood in Stool
- ❑ Change in Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Constipation
- ❑ *None in this Category*

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

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

**Eyes and Vision:**
- ❑ Wear Contacts/Glasses
- ❑ Blurred or Double Vision
- ❑ Eye Disease or Injury
- ❑ *None in this Category*

**Ears, Nose and Throat:**
- ❑ Swollen Glands in Neck
- ❑ Ringing in the Ears
- ❑ Ear-Ache/Ringing/Drainage
- ❑ Sinus/Allergy Problems
- ❑ *None in this Category*

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

**Endocrine, Hematologic, and Lymphatic:**
- ❑ Thyroid Problems
- ❑ Diabetes
- ❑ Cold Extremities
- ❑ Heat or Cold Intolerance
- ❑ Immune System Disorder
- ❑ *None in this Category*

**Skin and Breasts:**
- ❑ Rash or Itching
- ❑ Non-healing Sores
- ❑ Breast Pain
- ❑ Breast Lump
- ❑ Breast Discharge
- ❑ *None in this Category*

**Genitourinary:**
- ❑ Kidney Stones
- ❑ Burning/Painful Urination
- ❑ Change in Force/Strain w/Urination
- ❑ Frequent Urination
- ❑ Urinary Leakage or Bed Wetting
- ❑ Blood in Urine
- ❑ *None in this Category*

**Women Only:**

**Are you pregnant?**
- ❑ Yes-Due Date: _____
- ❑ No-Last Menstrual Period: _____
- ❑ Painful or Irregular Periods
- ❑ Urine Leakage with Coughing or Sneezing
- ❑ Urine Leakage with Laughing or Lifting
- ❑ *None in this Category*

**Pregnancies with Outcome & Date**

_____

_____

Other Conditions not listed:_____

**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. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient or Guardian Signature _____ Date_____

Doctor Signature _____ Date _____