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

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List all Medications With Dosage and Frequency (i.e. 5 mg once a day, etc.) ***Did you bring a list? Can we make a copy?***

☐ **NONE**

_____

_____

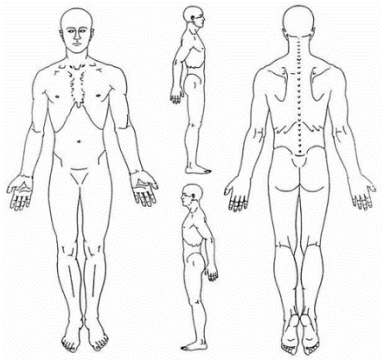
CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

Major Complaint: _____

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

Does It Radiate/Shoot To Any Areas Of Your Body? No / Yes **If yes, where:**_____

DRAW AREAS OF COMPLAINTS:



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

Is The Complaint: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Numb Other:_____

Is The Complaint: Constant / Off and On

What Makes It Better? Ice / Heat / Rest / Movement / Stretching / OTC Meds *(Advil, Tylenol, etc.)* / RX Meds

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:_____

HEALTH HISTORY *(PLEASE USE REVERSE SIDE OF PAGE IF NEEDED)*

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**:_____

Allergies to Medications: *(List and reactions)* ☐ **NONE**

_____

Vitamins & Supplements: *(List all and frequency*) ☐ **NONE**

_____

PAST HEALTH HISTORY: *(List even if it was 20 years ago…)*

Surgeries – *Date, Type and Reason*: ☐ **NONE**

_____

_____

Injuries, Traumas or Hospitalizations: *(Even 20 years ago or more)* ☐ **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 _____
- ❑ Painful Joints
- ❑ Stiff/Swollen Joints
- ❑ Sore/Weak Muscles or Joints
- ❑ Muscle Spasms/Cramps
- ❑ Broken Bones
- ❑ Other: _____
- ❑ *None in this Category*

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

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

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

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

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

Respiratory:
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Lung Problems
- ❑ Other: _____
- ❑ *None in this Category*

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

Ears, Nose and Throat:
- ❑ Bleeding Gums/Mouth Sores
- ❑ Bad Breath or Bad Taste
- ❑ Dental Problems
- ❑ Swollen Throat or Voice Change
- ❑ Swollen Glands in Neck
- ❑ Ringing in the Ears
- ❑ Ear-Ache/Ringing/Drainage
- ❑ Sinus/Allergy Problems
- ❑ Nose Bleeds
- ❑ Hearing Loss
- ❑ Other: _____
- ❑ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid Problems
- ❑ Diabetes
- ❑ Excessive Thirst or Urination
- ❑ Cold Extremities
- ❑ Heat or Cold Intolerance
- ❑ Change in Hat or Glove Size
- ❑ Dry Skin
- ❑ Glandular or Hormone Problem
- ❑ Swollen Glands
- ❑ Anemia
- ❑ Easily Bruise or Bleed
- ❑ Phlebitis
- ❑ Transfusion
- ❑ Immune System Disorder
- ❑ Other: _____
- ❑ *None in this Category*

Skin and Breasts:
- ❑ Rash or Itching
- ❑ Change in Skin Color
- ❑ Change in Hair or Nails
- ❑ Non-healing Sores
- ❑ Change of Appearance of a Mole
- ❑ Breast Pain
- ❑ Breast Lump
- ❑ Breast Discharge
- ❑ Other: _____
- ❑ *None in this Category*

Women Only:

Are you pregnant?
- ❑ Yes-Due Date _____
- ❑ No-Last Menstrual Period _____
- ❑ Infertility
- ❑ Painful or Irregular Periods
- ❑ Vaginal Discharge
- ❑ Urine Leakage with Coughing or Sneezing
- ❑ Urine Leakage with Laughing or Lifting
- ❑ Other: _____
- ❑ *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. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient or Guardian Signature _____ Date_____

Treating Doctor Signature _____ Date _____

AUTO ACCIDENT QUESTIONNAIRE

ACCIDENT INFORMATION *(Please use back of this page if needed.)*

Date of Accident: _____ **Number of People in Accident Vehicle** _____ **Name of Driver** *(If not you)* _____

Were you the: ❑ Driver ❑ Front Passenger ❑ Rear Passenger – Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row

Year/Make/Model of Vehicle you were in: _____

Were you wearing a seatbelt? ❑ Yes ❑ No **Is vehicle equipped with airbags?** ❑ Yes ❑ No **Did airbags inflate?** ❑ Yes ❑ No

Where was your vehicle impacted? ❑ Front ❑ Rear ❑ Driver side ❑ Passenger side

During impact, where were you facing? ❑ Forward ❑ Backward ❑ Left ❑ Right

Did any part of your body strike anything in the vehicle? ❑ No ❑ Yes *(Describe)* _____

_____

Did you lose consciousness? ❑ No ❑ Yes **For how long?** _____

Were you: ❑ Aware ❑ Surprised **by the impact?**

In your own words, please describe the accident in detail: _____

_____

_____

MEDICAL INFORMATION

Before the Accident

Have you ever had complaints in the involved area? ❑ No ❑ Yes

If yes, were they present at the time of the accident? ❑ No ❑ Yes *(Describe)* _____

Were you able to work without restrictions before the accident? ❑ Yes ❑ No

At the Time of the Accident

Did you feel pain immediately after the accident? ❑ Yes ❑ No – **When?** ❑ Later that Day ❑ Next Day ❑ When? _____

Did you go to a hospital or see any other doctor? ❑ No ❑ Yes – **When did you go?** ❑ Immediately ❑ Next Day ❑ Other

How did you get there? ❑ Ambulance ❑ Private Transportation – **Name of hospital and/or doctor:** _____

Were any x-rays taken? ❑ Yes ❑ No **Was any medication prescribed?** ❑ Yes ❑ No

Since the Accident

Are your symptoms: ❑ Getting Better ❑ Staying the Same ❑ Getting Worse

Have you been missed any work since this accident? ❑ No ❑ Yes *(Describe)* _____

Are your work activities restricted because of this injury? ❑ No ❑ Yes *(Describe)* _____

LEGAL INFORMATION

Did the police come to the scene of that accident? ❑ No ❑ Yes – **Was a police report filed?** ❑ Yes ❑ No

Have you retained an attorney? ❑ No ❑ Yes – **Name** _____ **Phone** _____

Your Auto Insurance Company _____ **Policy #** _____

Other Auto Insurance Company _____ **Claim #** _____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature_____ Date _____

Print Name *(First MI Last)*_____ Account # _____