

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: _____ SS Number: _____

Spouse/Significant Other: _____ Children and Ages: _____

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

We are a referral practice and as such, we like to thank those who refer to us.

Who referred you to our practice? _____

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: _____

Policy Holder: _____

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? _____

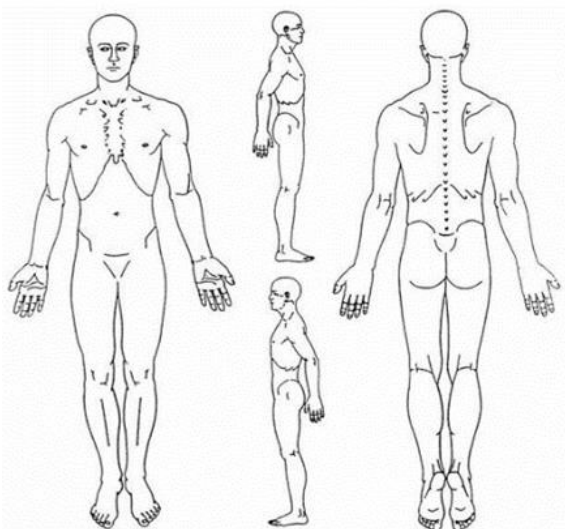
Intensity: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

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:



The image contains four line drawings of a human figure for marking complaint areas. From left to right: a front view, a left profile view, a right profile view, and a back view. Each drawing shows the head, torso, arms, and legs. The back view clearly shows the spine. The drawings are intended for the patient to draw or mark areas where they experience pain or other symptoms.

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 Unintentional 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
- Dizziness or Lightheaded
- Weakness
- Frequent or Recurrent Headaches
- Convulsions or Seizures
- Have you ever had a head injury?
- Had an auto accident? Year: _____
- None in this Category

Cardiovascular & Heart:

- Chest Pains
- Blood Pressure Problems
- Swelling of Hands, Ankles, or Feet
- Heart Problems
- None in this Category

Eyes and Vision:

- Blurred or Double Vision
- None in this Category

Ears, Nose and Throat:

- Ringing in the Ears
- Earache/Ringing/Drainage
- Sinus/Allergy Problems
- None in this Category

Mind/Stress:

- Sleep Problems
- Memory Loss or Confusion
- None in this Category

Gastrointestinal:

- Nausea or Vomiting
- Abdominal Pain
- None in this Category

Endocrine, Hematologic, and Lymphatic:

- Thyroid Problems
- Diabetes
- Immune System Disorder
- None in this Category

Respiratory:

- Difficulty Breathing
- Asthma or Wheezing
- Tobacco Use
- None in this Category

Genitourinary:

- Kidney Stones
- Burning/Painful Urination/Blood in Urine
- Bed Wetting
- None in this Category

Women Only:

Are you pregnant?

- Pregnant Due Date: _____
- No-Last Menstrual Period: _____
- Painful or Irregular Periods
- 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.

Patient or Guardian Signature _____ Date _____

Doctor Signature _____ Date _____