Patient Health History

Today's Date / / **Signature of Patient** _____

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** _____

Primary Phone _____ **Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Employer: _____ **Phone:**_____

Employer Address:_____ **Occupation:**_____

Spouse:_____ **Phone:**_____

Emergency Contact:_____ **Phone:**_____

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone

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

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

Employment Status *(check one)*

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

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 ❑ I choose not to specify ❑ Other

Continued ...

Verification Question *(choose only one question by circling 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.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker (Date quit :_____)
❑ Never been a smoker

If yes, how much do you currently smoke? ❑ 1-10 cigarettes per day ❑ 10-20 cigarettes per day
❑ More than 20 cigarettes per day

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) _____

Briefly list any major surgeries you may have had, or any major health problems.

1) _____ 3) _____

2) _____ 4) _____

Has any doctor diagnosed you with Hypertension (High Blood Pressure) presently? ❑ Yes ❑ No

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 spine in the past year? ❑ Yes ❑ No
If so, where were they taken? _____

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** ___ /___

Family & Personal History
Please list immediate family members (or yourself) who have the following conditions:

Cancer:	Liver Disease
Diabetes:	Mental Illness:
Heart Disease:	Thyroid Disease:
High Blood Pressure:	Arthritis:
Stroke:	Asthma:
Alzhemiers:	Allergies:

For women:
Are you pregnant? □Yes □No If so, how many weeks?_____
Are you nursing? □Yes □No
Are you taking birth control? □ Yes □ No

PLEASE READ AND SIGN
(FOR EVERYONE)

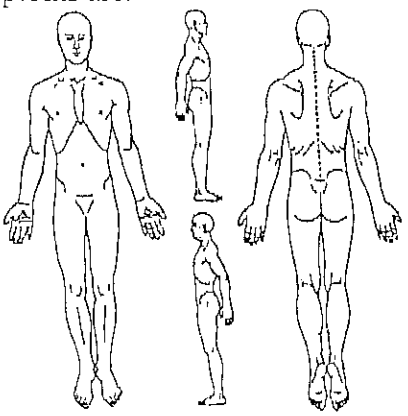
- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly mutual understating between provider and patient.
- Our policy requires payment in full for all services rendered at time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I understand that I am responsible for all copays, deductibles, co-insurance and balances.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- As with any form of healthcare, some risks are present, and although non-intentional by the provider, I am aware of these risks. I acknowledge that I can ask the provider any and all questions I may have regarding my healthcare.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I have provided.

Signature:_____ Date:____/____/____

Relationship to patient: □Self □Parent/Guardian □Spouse

Location of Symptom

With the problems you described in the last section in mind, please use the body diagram below to show where your symptoms are.



Nutritional Supplements

- ☐ Yes
- ☐ No

Review of Body Systems

A full review of the systems of the body helps us get a full picture of your health. Please let us know if you have any of the issues below or specify that you don't have any complaints in those areas of your body.

CIRCLE ALL THAT APPLY BELOW

Acne	Fainting	Numbness
Agina	Fatigue	Osteoporosis
Amphysema	Food sensitivities	Pins and needles
Anorexia/bulimia	Frequent infection	PMS symptoms
Anxiety	Hair loss	Pneumonia
Apnea	Hay fever	Poor appetite
Arthritis	Headache	Poor circulation
Asthma	Hearing loss	Prostate issues
Back Problems	Heartburn	Psoriasis
Bedwetting	High blood pressure	Rash
Blurred vision	High cholesterol	Ringing in ears
Cancer	Hypoglycemia	Scoliosis
Chronic ear infection	Immune disorders	Shortness of breath
Constipation	Infertility	Skin cancer
Depression	Kidney stones	Stroke
Diabetes	Loss of smell	Sudden weight gain/loss
Diarrhea	Loss of taste	Swollen glands
Dizziness	Low blood pressure	Thyroid issues
Eczema	Low energy	TMJ Issues
Erectile dysfunction	Low libido	Ulcer
Excessive Bruising	Neck Pain	Weakness

Problem Areas

Problem Areas
Describe Your Problem

Intensity: Indicate the intensity of your symptoms
1 2 3 4 5 6 7 8 9 10

Mechanism: How did your problem begin?

Onset date:
Duration and timing: How often do you experience your symptoms?

Quality: What is the nature of your symptoms?

- ☐ Dull
- ☐ Sharp
- ☐ Throbbing
- ☐ Burning
- ☐ Deep
- ☐ Aching
- ☐ Tingling
- ☐ Stabbing
- ☐ Cramping
- ☐ Numbness
- ☐ Radiating

Radiation: Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?

Aggravating or relieving factors: What makes it better or worse? Such as time of day, movements, certain activities, etc

Prior interventions: What have you done to relieve the symptoms?

- ☐ Prescription Medication
- ☐ Over the counter drugs
- ☐ Homeopathic remedies
- ☐ Physical Therapy
- ☐ Surgery
- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Massage
- ☐ Ice
- ☐ Heat
- ☐ Other

PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

Patient Name: (N) _____ Patient# _____
(Last) (First) (Middle)

✓ I have received the _____ Notice of Privacy Practices.

(N) _____ _____
Signature of Patient/Parent/Legal Guardian Date

_____ _____
Relationship to Patient Privacy Notice Version #

_____ _____
Witness Location Privacy Notice Written Acknowledgement was obtained (if more than one clinic location)

Documentation of Good Faith Effort

☐ Attempted to distribute the Notice of Privacy Practices to the patient/parent/legal guardian, but the patient, parent, legal guardian declined to acknowledge the receipt of the Notice of Privacy Practices.

☐ Patient/Parent/Legal Guardian stated they had already received the Privacy Notice.

☐ Patient/Parent/Legal Guardian directed our clinic's website to view the Notice of Privacy Practices.

☐ The Notice of Privacy Practices was mailed to the patient/parent/legal guardian.

☐ Other _____

_____ _____ _____
Witness Date