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 1 ____________

Address 2 ____________

City ____________ **State** ______ **Zip Code** ______

Primary Phone ____________ **Mobile Phone** ____________

Email ____________

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

Referred By ____________

Contact Method *(check one)*

❑ Primary Phone ❑ Mobile Phone ❑ Email

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

Type of Occupation ____________

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

Continued ...

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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 ☐ 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*

If former smoker how many years since you quit ______________________

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 your main health problems: ______________________

Has any doctor diagnosed you with Hypertension 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: ______________________

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ☐ Yes ☐ No

To be performed by clinic staff:

Height: ______ inches **Weight:** __________ pounds **BP:** ______ / ________ **Pulse** ________

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NAME: ______________________ DATE: __________

HEALTH QUESTIONNAIRE

Please indicate for each of the questions below your experience by use of one of the following codes:

(Codes) 1 - NEVER had 2 - PREVIOUSLY had 3 - PRESENTLY have

MUSCULO-SKELETAL SYSTEM CODE

___ Low back problems
___ Pain between shoulders
___ Neck problems
___ Arm problems
___ Leg problems
___ Swollen joints
___ Painful joints
___ Stiff joints
___ Sore muscles
___ Weak muscles
___ Walking problems
___ Ruptures
___ Broken bones

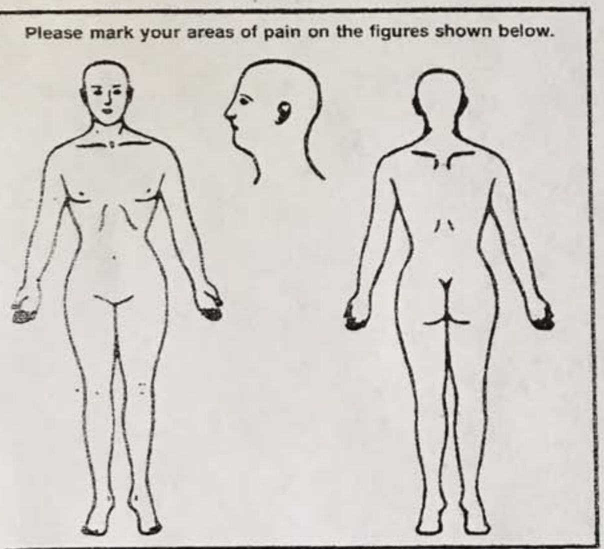
GENITO-URINARY SYSTEM CODE

___ Bladder trouble
___ Excessive urine
___ Scanty urination
___ Painful urination
___ Discolored urine

FEMALE CODE

___ Vaginal discharge
___ Vaginal bleeding
___ Vaginal pain
___ Breast pain
___ Lumps on breast

Please mark your areas of pain on the figures shown below.



GASTRO-INTESTINAL SYSTEM CODE

___ Poor appetite
___ Excessive hunger
___ Difficult chewing
___ Difficult swallowing
___ Excessive thirst
___ Nausea
___ Vomiting food
___ Vomiting blood
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Black stool
___ Bloody stool
___ Hemorrhoids
___ Liver trouble
___ Gall bladder problems
___ Weight trouble

NERVOUS SYSTEM CODE

___ Numbness
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches
___ Muscle jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression

CARDIO-VASCULAR-RESPIRATORY CODE

___ Chest pain
___ Difficult breathing
___ Persistent cough
___ Coughing phlegm
___ Coughing blood
___ Rapid heartbeat
___ Blood pressure problems
___ Heart problems
___ Lung problems
___ Varicose veins

EYE, EAR, NOSE AND THROAT CODE

___ Eye strain
___ Eye inflammation
___ Vision problems
___ Ear pain
___ Ear noises
___ Hearing loss
___ Ear discharge
___ Nose pain
___ Nose bleeding
___ Nose discharge
___ Difficult breathing thru nose
___ Sore gums
___ Dental problems
___ Sore mouth
___ Hoarseness
___ Difficult speech

Childhood diseases: ______________________

Complications: ______________________

Prior surgery: ______________________

Medication presently taking: ______________________

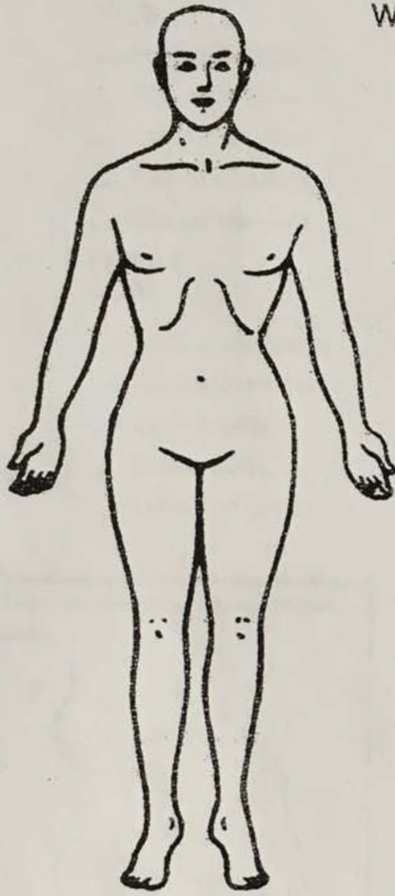
Previous accidents: ______________________

____

Mother living? ☐ Yes ☐ No In good health? ☐ Yes ☐ No

Father living? ☐ Yes ☐ No In good health? ☐ Yes ☐ No

On the illustrations below, please draw a line from the area of pain or injury to the word which most accurately describes it:



What kind of pain is it?

Sharp

Dull

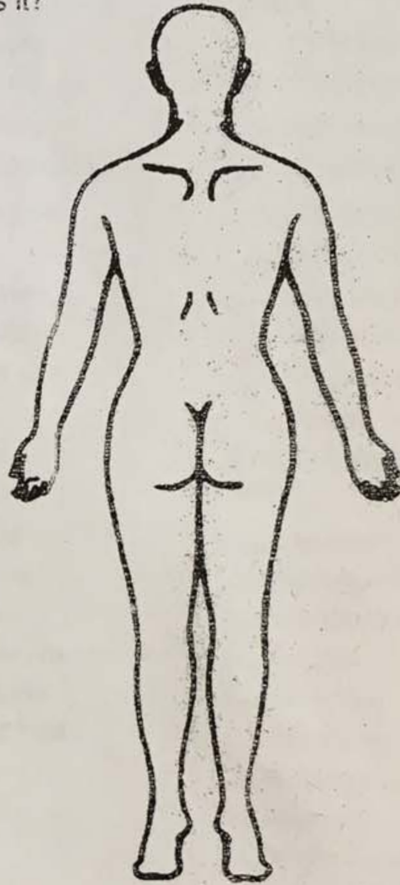
Tingling

Numbness

Constant

Comes & Goes

Other



It is worse when I: ____________________

____

Other comments: ____________________

____

____

____

____

Signed: ____________________ Date: __________

Patient