Patient Health History Patient ID:

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** _____

Street Address _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____**Secondary Phone** _____

Mobile Phone _____

Home Email _____ **Work Email** _____

Which email would you like us to use to communicate with you? ❑ Home ❑ Work

Best Contact Method *(check one):* ❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

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

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

Spouse's Name _____ **Children's Names & Ages** _____

Employment Status *(check one)* ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Employer _____ **Occupation/Job Title** _____

How did you hear about our office? _____

Race *(check one)* ❑ White ❑ Black/African American ❑ American Indian/Alaskan Native ❑ Asian
❑ Native Hawaiian/Pacific Island ❑ Other_____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ Chinese ❑ German ❑ Urdu ❑ American Sign Language
❑ French ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Gujarati
❑ Arabic ❑ Portuguese ❑ Japanese ❑ Other_____ ❑ I choose not to specify

Verification Question: *(Choose only one 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?

Verification Answer to the Chosen Question: _____
YOUR ANSWER MUST BE AT LEAST 6 CHARACTERS LONG

Do you currently smoke tobacco of any kind?

❑ Yes ❑ Never a smoker ❑ Former smoker: # Yrs Smoked_____ # Yrs Since You Quit_____

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 ❑ N/A
No interest *Very Interested*

List ALL current prescription and over-the-counter medications, including dosage. Check here if NONE: ❑

1) _____ **5)** _____

2) _____ **6)** _____

3) _____ **7)** _____

4) _____ **8)** _____

List ANY known allergies to medications. Check here if NONE: ❑

1) _____ **3)** _____

2) _____ **4)** _____

List ALL current nutritional supplements, vitamins, etc. including dosage. Check here if NONE: ❑

1) _____ **4)** _____

2) _____ **5)** _____

3) _____ **6)** _____

List ANY surgical procedures and dates. Check here if NONE: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Has any doctor diagnosed you with Hypertension 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

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

Health History: **Check here if NONE: ❑**

You / Family			You / Family			You / Family		
❑	❑	Diabetes	❑	❑	Thyroid Disease	❑	❑	Cardiovascular Disease
❑	❑	Heart Attack	❑	❑	Alzheimer's	❑	❑	Osteoporosis or Osteopenia
❑	❑	Stroke	❑	❑	Osteo-Arthritis	❑	❑	Rheumatoid Arthritis
❑	❑	Multiple Sclerosis	❑	❑	Gastro-Intestinal	❑	❑	High Cholesterol Controlled by meds? Y / N
❑	❑	Parkinson's	❑	❑	Kidney Disease	❑	❑	High Blood Pressure Controlled by meds? Y / N
❑	❑	Headache	❑	❑	Liver Disease	❑	❑	Fibromyalgia and/or Chronic Fatigue Syndrome
❑	❑	Migraine	❑	❑	Asthma	❑	❑	HIV/AIDS

❑ ❑ Cancer(s) _____

❑ ❑ Other _____

<u>Women Only: (For x-ray purposes)</u>

Is there any possibility of being pregnant? ❑ Yes ❑ No Do you currently use an IUD? ❑ Yes ❑ No

When was the FIRST day of your LAST menstrual cycle? _____

Lifestyle History:

STRESS LEVELS: ❑ None ❑ Minimal ❑ Moderate ❑ High Source(s) of your stress? _____

SLEEP: Average # Hours _____ **FAVORITE POSITION?:** ❑ Back ❑ Side Lt / Rt ❑ Stomach ❑ Restful or ❑ Restless

MATTRESS: Age:_____ years ❑ Soft ❑ Medium ❑ Firm ❑ Memory Foam ❑ Air ❑ Waterbed ❑ Other_____

PILLOW: Age:_____ years ❑ Feather/Down ❑ Memory Foam ❑ Water ❑ Orthopedic ❑ Other_____

MY DAILY DIET IS: ❑ Poor ❑ Fair ❑ Good ❑ Excellent **MY POSTURE IS:** ❑ Poor ❑ Fair ❑ Good ❑ Excellent

HANDED: ❑ Right ❑ Left ❑ Ambidex **Do you have orthotics or lifts in your shoes?:** ❑ No ❑ Yes, they are _____ yrs old.

WATER: ❑ I don't drink extra water. ❑ I drink _____ servings/day of water.

ALCOHOL: ❑ I don't drink alcohol. ❑ I drink an alcoholic beverage _____ (#)/day, or _____ (#)/week.

Check ALL that apply: ❑ Beer ❑ White Wine ❑ Red Wine ❑ Mixed Liquor Drinks

CAFFEINE: ❑ I don't consume caffeine. ❑ I consume ____ servings/day **IN MY** ❑ Soda ❑ Coffee ❑ Tea ❑ Chocolate

SWEETENERS: ❑ I don't use artificial sweeteners. ❑ I consume _____ servings/day. ❑ Equal ❑ Splenda ❑ Sweet n Low

MSG: ❑ I don't eat Mono Sodium Glutamate (MSG)? ❑ I consume _____ servings/day. ❑ **Not Sure**

Types of EXERCISE & Frequency: _____

Name of Previous Chiropractor? _____ **Date of last visit?** _____

List ANY current ALLERGIES you may have:

❑ Seasonal ❑ Shellfish ❑ Latex ❑ Sulfites ❑ Food _____ ❑ Other_____

CURRENT SYMPTOMS: (Check all that apply) **When did your symptoms begin?** _____

❑ Headaches/Migraine	❑ Arm tingling	❑ Leg tingling	❑ Ears ringing	❑ Dizziness/Vertigo
❑ Neck pain/stiffness	❑ Finger numbness	❑ Foot numbness	❑ Difficulty sleeping	❑ Sinus problems
❑ Back pain/stiffness	❑ Jaw pain/popping	❑ Facial pain	❑ PMS/Hormonal Imbalance	

Does pain radiate to: ❑ Head Rt/Lt ❑ Shoulder Rt/Lt ❑ Arm Rt/Lt ❑ Buttock Rt/Lt ❑ Leg Rt/Lt ❑ Rib Cage Rt/Lt

Do you have any other symptoms not listed above? _____

Are you experiencing any difficulty with:

❑ Sitting	❑ Standing Straight	❑ Lying down	❑ Walking
❑ Sitting to standing	❑ Bending/Twisting	❑ Lifting	❑ Coughing/Sneezing

Is the pain worse in the…❑ morning or ❑ evening **and after** ❑ normal or ❑ increased **activity.**

The pain interferes with my… ❑ work ❑ sleep ❑ personal activities ❑ other _____

Using the 0-10 scale below, how would you rate your symptoms overall? _____

(0) No symptoms (1 - 2) Mild (3 - 4) Uncomfortable (5 - 6) Moderate (7 - 8) Severe (9 - 10) Unbearable

List 3 main health concerns BELOW:	**Quality**	**Intensity**	**Frequency**
1._____	Dull, Sharp, Shoot, Burn	Mild, Mod, Severe	Intermit, Freq(3-4x/wk), Constant (Daily)
2._____	Dull, Sharp, Shoot, Burn	Mild, Mod, Severe	Intermit, Freq(3-4x/wk), Constant (Daily)
3._____	Dull, Sharp, Shoot, Burn	Mild, Mod, Severe	Intermit, Freq(3-4x/wk), Constant (Daily)

Office Use: _____

_____

Are there any other contributing factors you would like to discuss with the Doctor?_____

_____

Are you willing to do whatever you need to do to get the best results? ❑ YES ❑ NO ❑ Not Sure

Doctor's Signature_____ Date_____