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## 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** ____________________

**City** ____________________ **State** __________ **Zip Code** __________

**Primary Phone** ____________________ **Secondary Phone** ____________________

**Mobile Phone** ____________________

**Home Email** ____________________ **Work Email** ____________________

**Which email address would you like us to use to communicate with you?** *(check one)* ❑ Home ❑ Work

**Contact Method** *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

**Date of Birth** [ / / ] **Age** ______ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

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

**Referred by:** ❑ Yellow Pages ❑ Provider Directory ❑ Sign ❑ Friend__________ ❑ Doctor__________

**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 ❑ 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

**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 mothers' maiden name? ❑ When is your anniversary? ❑ What is your favorite color?

**Verification answer to the chosen question:** ____________________

**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*

**Current medications, including dosage if known.**
**If there are no current medications, check here:** ❑ **If you have attached a list, check here:** ❑

**1)** ____________________ **Start Date:** ________ **4)** ____________________ **Start Date:** ________

**2)** ____________________ **Start Date:** ________ **5)** ____________________ **Start Date:** ________

**3)** ____________________ **Start Date:** ________ **6)** ____________________ **Start Date:** ________

**List any known allergies you have had to any medications.**
**If no allergies are known, check here:** ❑ **If you have attached a list, check here:** ❑

____________________________________________________________

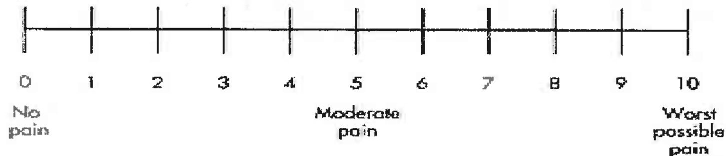
**Briefly list your main health problems:** ________________________________

____________________________________________________________

**Is this injury due to an auto accident?** ❑ Yes❑ No(___/___/___) **Work comp injury?** ❑ Yes❑ No(___/___/___)

**How long have you had this condition?** ____________ **What aggravates your condition?** ____________

**Please rate your pain:**




**Is your condition getting worse?** ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

**Have you ever broken any ribs or spinal bones?** ❑ Yes❑ No If yes, describe:____________________

**Has any doctor diagnosed you with hypertension presently?** ❑ Yes ❑ No If yes, describe: ____________

____________________________________________________________

**List surgical operations & dates:** ________________________________

**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:**____ / _____