**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 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.*

**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

**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

 ❑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 ❑ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ I choose not to specify

 **Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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*

**Do you currently drink alcohol of any kind?** ❑ Yes ❑ No

***If yes, how much do you drink per week:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***What type of drink do you primarly drink:*** ❑ Wine ❑ Beer ❑ Liquor

 **Do you use any illegal drugs?** ❑ Yes ❑ No

**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)**

**FAMILY HISTORY: please list if your mother, father, sisters or brothers have had...**

**DIABETES\_\_\_\_\_\_\_\_\_\_\_\_\_CANCER\_\_\_\_\_\_\_\_\_\_\_\_\_\_TUBERCULOSIS\_\_\_\_\_\_\_\_\_\_\_\_\_OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 low back spine in the past 28 days?** ❑ Yes ❑ No

 **To be performed by clinic staff:**

**Height:** inches **Weight:** pounds **BP:** /

|  |  |
| --- | --- |
| humans |  |
| **PLEASE DESCRIBE YOUR PRESENT PAIN FULLY AND ILLUSTRATE AND OUTLINE ON DRAWING.** |
|
|  |
|  |
|  |
|  |
|  |
|  |
|

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

 |
|  |
| **WHEN DID THIS PAIN OCCUR?** |  | **WHAT WERE YOU DOING?** |  |
|  |
|  | **HAVE YOU EVER HAD THIS PAIN BEFORE ?** |  |
|  |  |  |
| **DOES THIS PAIN HURT WORSE WHEN YOU SIT?** |  | **STAND** |  | **MOVE ABOUT** |  |
|  |
| **DOES THE PAIN INVOLVE A HIP** |  | **LEG** |  | **ANKLE** |  | **FOOT** |  | **WHICH ONE** |  |
|  |
| **DOES YOUR LEG BECOME NUMB?** |  | **DOES YOUR FOOT FEEL NUMB** |  | **DOES YOUR BACK HURT WORSE** |
|  |
| **WHEN IN BED?** |  | **DO YOU HAVE NIGHT SWEATS?** |  | **DOES IT PAIN YOU WHEN YOU BEND FORWARD?** |  |
|  |
| **IS YOUR PAIN CONSTANT?** |  | **GIVE YOUR CHIROPRACTIC HISTORY** |  |
|  |
|  |
|  |
| **RESULTS FROM PREVIOUS CHIROPRACTIC CARE** |  |
|  |
|  |
| **WHAT APPLICATIONS HELP** |  | **WORSEN** |  |
|  |
| **HAVE YOU BEEN X-RAYED DURING THE PAST SIX MONTHS** |  | **WHAT WAS X-RAYED** |  |
|  |

|  |  |
| --- | --- |
| **LIST WHAT YOU HAD FOR BREAKFAST:** |  |
|  |
| **LUNCH:** |  |
|  |
| **SUPPER:** |  |
|  |
|  |
| **HOW MUCH COFFEE DO YOU DRINK EACH DAY?** |  | **BLACK** |  | **CREAM** |  | **SUGAR** | **ARTIFICIAL SWEETENER** |  |
|  |
| **LIST YOUR ACCIDENT’S AND GIVE DATE’S** |  |
|  |
|  |
|  |
|  |
| **LIST YOUR MAJOR DISEASES AND GIVE DATE’S** |  |
|  |
|  |
|  |
|  |
|  |
| **SURGERY:** |  |
|  |
|  |
|  |
| **YOUR PRESENT COMPLAINT:** | **Does your present complaint involve any of the following:** |
|  |
| **HEART PAINS** |  | **LEFT CHEST PAINS** |  | **RIGHT CHEST PAINS** |  | **LEFT ARM PAINS**  |  |
|  |
| **RIGHT ARM PAINS** |  | **IS YOUR PAIN WORSE ON EXERTION** |  | **SITTING** |  | **STANDING** |  |
|  |
| **DOES YOU PAIN INVOLVE . . .**  | **STOMACH** |  | **RIGHT LOWER RIBS** |  | **LEFT LOWER RIBS** |  |
|  |
| **DOES YOU PAIN APPEAR BEFORE . . . . .**  |
|  |
| **EATING** |  | **AFTER EATING** |  | **1 HOUR AFTER** |  | **2 HOURS AFTER** |  | **3 HOURS AFTER** |  |
|  |
| **DO YOU HAVE HEADACHES** |  | **WHAT PART OF YOUR HEAD IS INVOLVED?** |  |
|  |
| **DOES YOUR HEADACHE APPEAR WHEN YOU AWAKEN IN THE MORNING?** |  | **BEFORE NOON** |  |
|  |
| **BEFORE SUPPER** |  | **BOWEL FUNCTION; Are you constipated?** |  | **Is your stool Hard?** |  |
|  |
| **Marble like** |  | **Watery** |  | **Do you see long strings of mucus in your stools** |  |
|  |
| **DO YOU GET UP NIGHTS TO URINATE** |  | **HOW OFTEN** |  | **BURNING** |  | **DISCOLORATION** |  |
|  |
| **DOES YOUR URINE STAIN YOUR UNDERCLOTHING** |  | **DO YOU FEEL AS THOUGH YOUR BLADDER DID NOT EMPTY** |  |
|  |
| **DO YOU SUFFER FROM GAS** |  | **IS YOUR MOUTH OR TOUNGE SORE** |  | **DO YOU HAVE CANKER SORES** |  |
|  |
| **ARE YOU SHORT OF BREATH** |  | **DO YOU COUGH** |  | **DO YOU WORRY UNNECESSARILY** |  |
|  |
| **DO YOU DREAM** |  | **HAVE YOUR HANDS EVER TREMBLED WHILE YOUR WORKING** |  |
|  |
| **DO YOU LEGS FEEL WEAK AT TIMES** |  | **HAVE YOU ANY DIZZINESS** |  |
|  |
| **DO YOUR HANDS OR FEET BECOME COLD** |  | **NUMB** |  | **DO YOUR EYES TROUBLE YOU** |  |
|  |
| **DOES THE COMPANY OF PEOPLE BOTHER YOU** |  | **DOES YOUR THROAT BECOME PAINFUL** |  |
|  |
| **DOES YOU VOICE BECOME HOARSE** |  | **DO YOU HAVE HEAD OR EAR NOISES** |  |
|  |
| **DO YOU HAVE SPOTS BEFORE YOUR EYES** |  |  |