Patient Health History

Staff Use Only: Chart_____

Today's Date ____/____/____ **Signature (Patient or Responsible Party)** _____

Name of Parent or Guardian (if patient is under age 18) _____

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** _____

Preferred Contact Method *(check one)* ❑Home ❑Work ❑Mobile

Home Phone _____ **Mobile Phone** _____

Place of Employment _____ **Work Phone** _____

Date of Birth ____/____/____ **Age** _____

Gender ❑Male ❑Female ❑Unspecified **Marital Status** ❑Single ❑Married ❑Other **# of Children** _____

Employment Status *(check one)*

❑ Employed ❑ Full-Time Student ❑ Part-Time Student ❑ Other ❑ Retired ❑ Self Employed

SSN (optional)_____

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ Other _____ ❑ I choose not to specify

Were you recommended to us? YES__ NO__ By whom? (optional) _____

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

Alcoholic drinks per week consumed _____

Are you pregnant? ❑ Yes ❑ No

Have you had any serious falls? ❑ Yes ❑ No **Have you had any sports injuries?** ❑ Yes ❑ No

Have you ever had a car accident? ❑Yes ❑No **When?** _____ **Area of injury** _____

Have you ever had a joint replacement? ❑Yes ❑No **When?** _____ **Which joint?** _____

Please complete additional questions on back > > > > > > > > >

List current medications. ***If you have a printed list of your medications at home, you can skip this section and bring the list to your next appointment.*** **If no current medications, check here: ❑**

1) _____ **4)** _____

2) _____ **5)** _____

3) _____ **6)** _____

List any known allergies you have had to any medications. If no medication allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: _____

_____

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

Have you ever had chiropractic care before? _____ From whom?_____

Family Physician's Name _____ **Name of clinic** _____

Past surgeries (include year):_____

_____

Personal Medical History: Present/Past Illness /Conditions (Review Of Systems):					
☐ AIDS	☐ Chest pain	☐ Dizziness	☐ HIV/ARC	☐ Polio	☐ Stomach Problems
☐ Allergies	☐ Circulation	☐ Epilepsy	☐ Kidney trouble	☐ Prostate trouble	☐ Thyroid trouble
☐ Anemia	☐ Cirrhosis/hepatitis	☐ Hay Fever	☐ Low Blood Pressure	☐ Rheumatic fever	☐ Tuberculosis
☐ Arthritis	☐ Diabetes	☐ Headaches	☐ Menstrual Troubles	☐ Scoliosis	☐ Ulcer
☐ Asthma	☐ Digestive Issues	☐ Hearing Problems	☐ Mental / Emotional Issues	☐ Sinus trouble	☐ Urination
☐ Bone fracture	☐ Dislocated joints	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ Vision Problems
☐ Cancer	☐ Diverticulitis	☐ High blood pressure	☐ Pacemaker	☐ STD'S	☐ Walking Problems
Other:					

Family History of Illness: (*specify F-Father, M-Mother, B-Brother, S-Sister, D-Daughter, SN-Son*)		
☐ Cancer (specify type):	☐ Heart Disease	☐ Osteoporosis
☐ Clotting Disorder	☐ High Cholesterol	☐ Psychological Disorder
☐ Dementia/Alzheimers	☐ Hypertension	☐ Septicemia
☐ Diabetes/Pre-Diabetes/Metabolic Syndrome	☐ Kidney Disease	☐ Stroke/Brain Attack
☐ Gastrointestinal Disorder	☐ Lung Disease	☐ Sudden Infant Death Syndrome
Other:		