# Patient Health History

**Today's Date** / /

**First Name**_____ **Nick Name**_____

**Last Name** _____ **Middle Name** _____**Suffix** _____

**Address 1** _____

**City**_____ **State**_____ **Zip Code** _____

**Mobile Phone** _____ **Secondary Phone** _____

**Home email** _____ **Work Email** _____

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

**How did you hear about our office?**

❑ Google Search ❑ Driving by the office ❑ Friend: _____ ❑ Other: _____

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

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

**Date of Birth** / / **Age** _____ **Gender** ❑ Male ❑ Female

**Social Security Number** _____

**Marital Status** *(check one)* ❑ Single ❑ Married ❑ Other **Spouse's Name** _____

**Emergency Contact** _____ **Phone**_____ **Relation**_____

**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 |

**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 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? *Answers must be at least 6 characters.*

**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 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)** | |

**What brings you to our office today? List your main complaints in order of severity:**

**1.** _____ **For how long?** _____

**2.** _____ **For how long?** _____

**3.** _____ **For how long?** _____

**Is this related to a work injury or auto accident?** _____

**Do you have any type of Health Insurance?** _____ **Company?** _____

**Policy #** _____ **Policy Holder's Date of Birth** _____

**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

***Notice: All new patients require an examination prior to treatment to properly document the necessity of care and to determine the appropriate treatment. Payment for services is expected at time of service. We will do our best to determine your health insurance benefits, but ultimately you will be personally responsible for payment regardless of your insurance coverage.***

**Signature of Patient** _____ **Date** _____

**To be performed by clinic staff:**

**Height:** _____inches **Weight:** _____ pounds **BP:** ____ / _____