

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: _____

Continued ...

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.

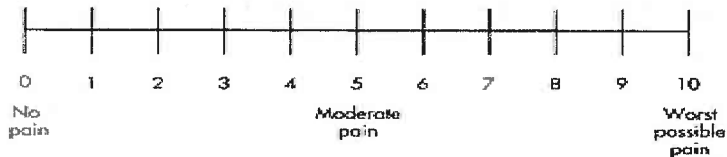
If no allergies are known, check here: If you have attached a list, check here:

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 low back spine in the past 28 days? Yes No

To be performed by clinic staff:

Height: _____ inches Weight: _____ pounds BP: _____ / _____