



**Patient Health History**

**Date:** \_\_\_\_\_

**Patient Title:** (check one)  Mr.  Mrs.  Ms.  Miss  Dr.  Prof.  Rev.

**First Name** \_\_\_\_\_ **Nick Name** \_\_\_\_\_

**Last Name** \_\_\_\_\_ **Middle Name** \_\_\_\_\_ **Suffix** \_\_\_\_\_

*\*If your address has not changed since you became a patient here, skip the following 2 lines*

**\*Address 1** \_\_\_\_\_

**\*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 **SSN** \_\_\_\_\_

**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

Continued ...





**Reason For Visit**

Please describe the pain & its location: \_\_\_\_\_  
\_\_\_\_\_

The reason for this visit is a result of (please circle): work, sports, auto, trauma or chronic

Please explain: \_\_\_\_\_  
\_\_\_\_\_

When did condition begin? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Is this condition getting worse (please circle)? YES NO Constant Comes and Goes

Is this condition interfering with your (please circle): work, sleep, or daily routine

If so, please explain: \_\_\_\_\_

Have you had this or similar conditions in the past? YES NO

If so, please explain: \_\_\_\_\_

Have you been treated by a Medical Physician for this condition? YES NO

If so, where? \_\_\_\_\_

Have you ever been treated by a Chiropractor before? YES NO

How long ago? \_\_\_\_\_ Do you have a preferred technique? \_\_\_\_\_

**About You**

Who can we thank for telling you about our office? \_\_\_\_\_

Employer: \_\_\_\_\_ How long? \_\_\_\_\_

Occupation: \_\_\_\_\_

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name (if applicable): \_\_\_\_\_

Do you have children: YES NO How Many? \_\_\_\_\_

Do you have any of the following diseases or conditions (currently or in the past)?

Y N Heart Attack / Stroke	Y N Heart Surg. / Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+ / AIDS	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema / Glaucoma	Y N Anemia
Y N High / Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe / Frequent Headaches	Y N Kidney Problems	Y N Ulcers / Colitis
Y N Fainting / Seizures / Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes / Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones / Joints	Y N Arthritis

Please list any other serious medical condition(s) you have or ever had: \_\_\_\_\_

List previous inpatient surgeries / treatments with dates: \_\_\_\_\_

List previous outpatient surgeries / treatments with dates: \_\_\_\_\_

List any past serious accidents with dates: \_\_\_\_\_

Family Health History and relationship: \_\_\_\_\_

Do you take Vitamins or Supplements? YES NO    Exercise? YES NO

Are you on a special diet? YES NO    Since: \_\_\_\_/\_\_\_\_/\_\_\_\_

For WOMEN: Are you taking Birth control? YES NO (please circle) Pill Patch IUD

Are you Pregnant? NO YES How far along? \_\_\_\_\_ Nursing? YES NO

**In Event of Emergency:**

Who should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_ Phone? \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_ Phone? \_\_\_\_\_