Patient Health History

Date	I.D. #

Name: _____ Age: _____ Date of Birth: _____ Sex: ❑M❑F

Address: _____ City: _____ State:____ Zip: _____

Phone (Home):_____(Work):_____(Cell):_____

Which phone number is your preferred method of contact: ❑ Home ❑ Work ❑ Cell

Email Address:_____ Marital Status: ❑S ❑M ❑D ❑W Number of Children: _____

I give you permission to email me appointment reminders, special offers, newsletters, birthday cards, etc. ❑Yes ❑No

Occupation: _____

Employer: _____ Driver's License Number: _____

Emergency Contact's Name: _____ Relationship:_____

Insured's Name: _____ Insured's Phone: _____ Insured's Date of Birth: _____

Insurance Company: _____

How did you hear about this office: _____ Referred by: _____

Past care for this condition: ❑Yes ❑No When? _____ By whom?: _____ Results: _____

Medical Doctor's Name: _____ Affiliation: ❑Spectrum ❑Metro ❑Mercy – St. Marys ❑Other: _____

I give you permission to send my Medical Doctor a report regarding my diagnosis/care. ❑Yes ❑No

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Are your present problems due to an injury? ❑Yes ❑No ❑On Job ❑Auto Accident ❑Personal Injury ❑Other: _____

Has the accident been reported? ❑Yes ❑No ❑To Employer ❑Auto Carrier ❑Other: _____

Are you now or have you ever been disabled? (Service or Work)? ❑Yes ❑No When? _____

Have you retained an attorney? ❑Yes ❑No Name & Address: _____

What is your current work status?

❑Full time, no restrictions ❑Full time, restrictions ❑Full time Homemaker ❑Full time student

❑Part time, no restrictions ❑Part time, restrictions ❑Retired ❑Unemployed

❑Off work due to restrictions ❑Other _____

List any accidents or falls and dates: ❑Auto: _____ ❑Recreation: _____

❑Sports: _____ ❑Work Related: _____ ❑Other: _____

List any broken bones (fractures) or dislocations: _____

Have you ever had X-rays taken? ❑Yes ❑No When? _____ By Whom? _____

For what ailments were these X-rays made? _____

Do you wear orthotics or heal lifts? ❑Yes ❑No Fitted by whom? _____ When? _____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No _____

Are you presently taking any medication, prescription, over-the-counter, home remedies, vitamins, minerals, etc?

(Please list) _____

OPERATIONS AND PROCEDURES

❑ I have never had any operations or surgeries

DATE		DATE		DATE	
_____	Vaccinations	_____	Spinal Taps/Injections	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach

Other _____

Please check the correct box for each item below. Check at least one box for each sign or symptom listed.

Never	Previously	Presently	GENERAL SYMPTOMS
❑	❑	❑	Allergy(what) _____
			_____
❑	❑	❑	Bronchitis
❑	❑	❑	Chills (Constant)
❑	❑	❑	Convulsions
❑	❑	❑	Dizziness
❑	❑	❑	Fainting
❑	❑	❑	Fatigue
❑	❑	❑	Headache
❑	❑	❑	Loss of Sleep
❑	❑	❑	Loss of Weight
❑	❑	❑	Nervousness
❑	❑	❑	Night Sweats
❑	❑	❑	Numbness or Pain in arms/legs/hands
❑	❑	❑	Wheezing

MUSCLES & JOINTS

❑	❑	❑	Backache
❑	❑	❑	Foot Trouble
❑	❑	❑	Hernia
❑	❑	❑	Pain Between Shoulders
❑	❑	❑	Painful Tail Bone
❑	❑	❑	Stiff Neck
❑	❑	❑	Spinal Curvature
❑	❑	❑	Swollen Joints
❑	❑	❑	Tremors
❑	❑	❑	Twitching

Never	Previously	Presently	GASTRO-INTESTINAL
❑	❑	❑	Belching or Gas
❑	❑	❑	Colon Trouble
❑	❑	❑	Constipation
❑	❑	❑	Diarrhea
❑	❑	❑	Gall Bladder Trouble
❑	❑	❑	Hemorrhoids (piles)
❑	❑	❑	Jaundice
❑	❑	❑	Liver Trouble
❑	❑	❑	Nausea
❑	❑	❑	Stomach Pain
❑	❑	❑	Vomiting
❑	❑	❑	Vomiting Blood
❑	❑	❑	Heart Burn
❑	❑	❑	Bloody Stools
❑	❑	❑	Acid Reflux
❑	❑	❑	Irritable Bowel

CARDIO-VASCULAR

❑	❑	❑	High Blood Pressure
❑	❑	❑	Low Blood Pressure
❑	❑	❑	Chest Pain
❑	❑	❑	Heart Trouble
❑	❑	❑	Poor Circulation
❑	❑	❑	Rapid Heart
❑	❑	❑	Slow Heart
❑	❑	❑	Strokes
❑	❑	❑	Swelling Ankles
❑	❑	❑	Varicose Veins

Never	Previously	Presently	NOSE/THROAT/EYE/EAR
❑	❑	❑	Asthma
❑	❑	❑	Deafness
❑	❑	❑	Earache
❑	❑	❑	Ear Discharge
❑	❑	❑	Ear Noises
❑	❑	❑	Thyroid Problems
❑	❑	❑	Frequent Colds
❑	❑	❑	Hay Fever
❑	❑	❑	Nasal Obstruction
❑	❑	❑	Nose Bleeds
❑	❑	❑	Pain in Eyes
❑	❑	❑	Poor Vision
❑	❑	❑	Blurred Vision
❑	❑	❑	Sinusitis
❑	❑	❑	Sore Throats
❑	❑	❑	Tonsillitis

SKIN OR ALLERGIES

❑	❑	❑	Bruising Easily
❑	❑	❑	Dryness
❑	❑	❑	Eczema
❑	❑	❑	Hives or Allergy
❑	❑	❑	Itching
❑	❑	❑	Sensitive Skin
❑	❑	❑	Skin Eruptions

Never	Previously	Presently	RESPIRATORY
❑	❑	❑	Chest Pain
❑	❑	❑	Chronic Cough
❑	❑	❑	Difficulty Breathing
❑	❑	❑	Spitting Blood
❑	❑	❑	Spitting Phlegm

GENITO-URINARY

❑	❑	❑	Bed Wetting
❑	❑	❑	Blood in Urine
❑	❑	❑	Frequent Urination
❑	❑	❑	Inability to Control
❑	❑	❑	Urine
❑	❑	❑	Kidney Infection
❑	❑	❑	Kidney Stones
❑	❑	❑	Painful Urination
❑	❑	❑	Prostate Trouble

FOR FEMALES ONLY

❑	❑	❑	Cramps
❑	❑	❑	Hot Flashes
❑	❑	❑	Irregular Cycle
❑	❑	❑	Painful Periods
❑	❑	❑	Vaginal Discharge

Pregnant at this Time

❑Yes ❑No

Last Pap Date _____

Last Menstrual Cycle _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

HABITS

❑Smoking Packs/day: _____

❑Drinking Alcohol: (Cups/day) _____

❑Coffee Cups/Day: _____

❑Soft Drink Bottles or Cans/Day: _____

❑Water Cups/Day: _____

EXERCISE

❑None

❑Moderate

❑Daily

Type: _____

_____

FAMILY HISTORY

	Diabetes	Kidney	Cancer	Back	Heart
Mother	❑	❑	❑	❑	❑
Father	❑	❑	❑	❑	❑
Brother(s), # of ___	❑	❑	❑	❑	❑
Sister(s), # of ____	❑	❑	❑	❑	❑

I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. I understand that this office/provider does not participate with any insurance company except Federal Medicare. Payment is due at time of service and any amount authorized to be paid by an insurance company directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsible for payment, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that any unpaid balance after 30 days of invoice will be subject to simple interest at the rate of 7% per year, until balance is paid in full. In addition, delinquent accounts will be charged a rebilling fee of $15 per month. If we choose not to charge the interest or rebilling fee for one or more months, that does not prevent us from charging them in any other month. I authorize the doctor to release all information necessary to communicate with personal physicians and other health care providers and payers to secure the payment of benefits.

I hereby authorize the doctor or therapist to examine and treat my condition as he/she deems appropriate, and I give authority for these procedures to be performed.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient Signature: _____ **Date**: _____

Guardian Signature Authorizing Care: _____ **Date**: _____

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CURRENT PATIENT COMPLAINT HISTORY

Patient Name: _____ **Date:** _____

Primary Complaint: _____

Pain Level: (*Please circle one*.) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

When did this begin - Date: _____ Has this occurred before? (Yes/No) Date of first occurrence: _____

Secondary or related complaint (if any):

_____

Please check all boxes that apply to your condition **and fill in the spaces that describe your present complaint(s).**

Has anyone treated you for this episode? ☐Yes ☐No If yes, by whom? _____

How did your symptoms begin?

☐Immediately after a specific incident ☐After multiple incidents ☐Gradually developed over time ☐Other _____

What makes your symptoms better?

☐Nothing ☐Lying down ☐Standing ☐Sitting ☐Movement/Exercise ☐Other _____

What makes your symptoms worse?

☐Nothing ☐Lying down ☐Standing ☐Sitting ☐Movement/Exercise ☐Other _____

Are your symptoms?

☐Decreasing ☐Increasing ☐Not Changing ☐Other _____

Description of pain or symptoms:

☐Sharp ☐Shooting ☐Dull ☐Burning ☐Ache ☐Numb/Tingling ☐Weakness ☐Stiff ☐Throbbing ☐Other _____

Does your pain move or radiate?

☐Yes ☐No - (If yes, where?) _____

Check the best and worse times of the day for your pain:

Best	Worst
☐First Awake	☐First Awake
☐Morning	☐Morning
☐Afternoon	☐Afternoon
☐Evening	☐Evening
☐Nighttime	☐Nighttime

Frequency of pain or symptoms:

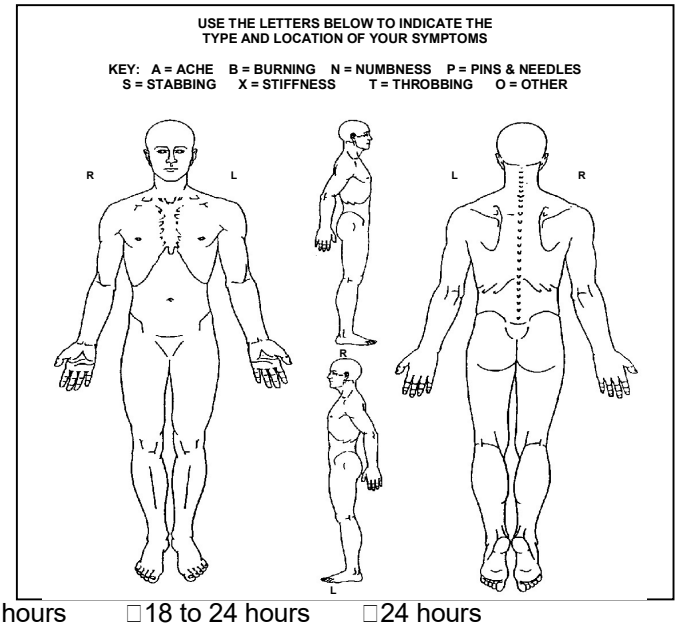
☐Constant (76 – 100%) ☐Frequent (51 – 75%)
☐Occasional (26 – 50%) ☐Intermittent (25% or less)

How many days out of an average week are you in pain?

(Please circle one) 1 2 3 4 5 6 7

How much time during the day are you in pain?

☐less than 1 hour ☐1 to 6 hours ☐6 to 12 hours ☐12 to 18 hours ☐18 to 24 hours ☐24 hours



What does your condition prevent you from normally doing?

_____

What is your long term goal (e.g. Move better, live without pain, age gracefully)?

_____

Is there anything else I should know? _____

Patient/Guardian Signature: _____ **Date:** _____

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