**Patient Health History**

/ /

**Today’s Date**

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

**Last Name Middle Name Suffix**

**Address**

**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.*

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

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Email

/ /

**Date of Birth Age**  **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

**Marital Status** *(check one)* ❑ Single ❑ Married ❑ Other

**Are you Pregnant (check on) ❑ Yes ❑ No**

**Employment Status** *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

**How were you referred to the office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you currently smoke tobacco of any kind?** ❑ Yes ❑ Former smoker ❑ Never been a smoker

**Current medications or provide a list. If there are no current medications, check here: ❑**

**1) 5)**

**2) 6)**

**3) 7)**

**4) 8)**

**List any known allergies including any allergies to medications.**

**If no allergies are known, check here: ❑**

**Reason for visit today:**

**How and When did your symptoms appear?**

**Please rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)**

**Has the condition recently been: [ ] Improved [ ] Worsened [ ] Unchanged**

**Please list any automobile accidents, head injuries, broken bones, dislocations, and surgeries/ injuries you have had:**

**Place a mark “Yes” or “No” to indicate if you have had any of the following:**

**AIDS/HIV [ ]Yes [ ]No Chemical Dependency [ ]Yes [ ]No Pinched Nerve [ ]Yes [ ]No**

**Alcoholism [ ]Yes [ ]No Chicken Pox [ ]Yes [ ]No Pneumonia [ ]Yes [ ]No**

**Allergy Shots [ ]Yes [ ]No Liver Disease [ ]Yes [ ]No Polio [ ]Yes [ ]No**

**Anemia [ ]Yes [ ]No Measles [ ]Yes [ ]No Prostate Problem [ ]Yes [ ]No**

**Anorexia [ ]Yes [ ]No Headaches [ ]Yes [ ]No Rheumatoid Arthritis [ ]Yes [ ]No**

**Appendicitis [ ]Yes [ ]No Miscarriage [ ]Yes [ ]No Rheumatic Fever [ ]Yes [ ]No**

**Arthritis [ ]Yes [ ]No Mononucleosis (Mono) [ ]Yes [ ]No Scarlet Fever [ ]Yes [ ]No**

**Asthma [ ]Yes [ ]No Multiple Sclerosis [ ]Yes [ ]No Stroke [ ]Yes [ ]No**

**Bleeding Disorders [ ]Yes [ ]No Mumps [ ]Yes [ ]No Thyroid Problems [ ]Yes [ ]No**

**Breast Lump [ ]Yes [ ]No Osteoporosis [ ]Yes [ ]No Tuberculosis [ ]Yes [ ]No**

**Bronchitis [ ]Yes [ ]No Pacemaker [ ]Yes [ ]No Tumors Growths [ ]Yes [ ]No**

**Cancer [ ]Yes [ ]No Parkinson’s /Alzheimer’s [ ]Yes [ ]No Ulcer [ ]Yes [ ]No**

**Diabetes [ ]Yes [ ]No High Blood Pressure [ ]Yes [ ]No Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient (or guardian if minor) Date:**