HEALTH HISTORY FORM

PATIENT NAME: _____ **DATE:** _____

AGE: _____ **HEIGHT:**_____ **WEIGHT:**_____

CHIEF COMPLAINT: Please list main body part(s) we will be treating *(Per insurance guidelines only 1 body part per visit is worked on)*
1._____ 2._____ 3._____
Have you had any recent x-rays or lab work relating to this complaint? If yes, when and where?_____
_____

HISTORY OF PRESENT COMPLAINT:
Does this pain/problem occur at a specific time? If yes, when? _____
What other signs/symptoms are you having? _____
How long have you had this pain/problem/Date of Injury? _____
What makes this pain/problem worse/better? Please list:_____
Have you had any previous episodes? If yes, when? _____

PATIENT MEDICAL HISTORY (Circle One)						
Diabetes	No	Yes		Hypertension	No	Yes
Cancer	No	Yes		Stroke	No	Yes
Heart Disease	No	Yes		Arthritis/Gout	No	Yes
Convulsions	No	Yes		Bleeding Tendency	No	Yes
Thyroid Disease	No	Yes		Vascular Disease	No	Yes
Hereditary Disease	No	Yes		Asthma	No	Yes
Osteoporosis	No	Yes		Pacemaker	No	Yes
Pregnant	No	Yes		Metal/Hardware in body	No	Yes

IF ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN (DATE/DIAGNOSIS):_____
_____
_____
_____

PAST SURGICAL HISTORY/PREVIOUS HOSPITALIZATIONS/SERIOUS INJURIES:_____
_____
_____
_____

MEDICATIONS: _____

Are you allergic to any medicine? If so, please list _____
Are you allergic to any food? If yes, please list _____
Are you taking any Herbal supplements/Vitamins? If yes, please list_____

PATIENT SOCIAL HISTORY:
Marital Status: Single_____ Married____ Separated____ Divorced_____Widowed_____
Use of Alcohol: Never_____Rarely_____Moderate_____Daily_____
Use of Tobacco: Never_____Previously, but quit _____Current_____# of packs per day_____
Use of Drugs: Never_____Type/Frequency _____

EMERGENCY CONTACT: Name:_____**Phone No.:**_____
Relationship to patient:_____