Patient Health History

Today's Date / /

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

Address 2 _____

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 ❑ Email

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

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

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 ❑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 ❑ Other _____ ❑ 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 favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____

Answers must be at least 6 characters.

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

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ **2)** _____

Continued …

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

1) _____ **4)** _____

2) _____ **5)** _____

3) _____ **6)** _____

Briefly list your main health problems or reason for visit: _____

_____

When did the problem begin? _____

Have you seen any other provider for this condition? _____

Have you ever injured your spine (head, neck, rib/chest area, back, pelvis or hips)? ☐Y ☐ N

Have you ever had any accidents related to any of the following? (check all that apply)

☐ Automobile ☐ Motorcycle ☐ Bicycle ☐ Sports ☐ Abuse ☐ Other

If yes, please explain:_____

Review of Systems: *(please mark "Y" for conditions you have now, and "P" for conditions in the past)*

Skin problems ☐Y ☐P Head Problems ☐Y ☐P Ear Problems ☐Y ☐P Neck Problems ☐Y ☐P

Respiratory Problems ☐Y ☐P Cardiovascular Problems/Chest Pain ☐Y ☐P Urinary Problems ☐Y ☐P

Gastrointestinal Problems ☐Y ☐P Please describe any marks: _____

Has any doctor diagnosed you with Hypertension (high blood pressure) presently? ❑ Yes ❑ No

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

Patient is fully responsible for all charges incurred including but not limited to any deductible and co-pay. Eagle Valley Chiropractic will file all charges with your insurance company (if you choose), and any unpaid amount is your responsibility. My signature below acknowledges that I understand and agree to the above terms and that all information on the intake form is true to the best of my knowledge.

Insurance Subscriber: _____ **Subscriber's Date of Birth:** _____

Signature of Patient/Parent if under 18: _____

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____