Patient Health History

Today's Date / / **Signature of Patient** _____

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

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 ❑ Home Email ❑ Work Email

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

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

Spouse Name_____**Date of Birth**_____**Phone**_____

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	

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

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

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

		Start Date			Start Date
1)			**5)**		
2)			**6)**		
3)			**7)**		
4)			**8)**		

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

1) _____ **3)** _____

2) _____ **4)** _____

List any current or past surgeries with dates if known.

1) _____ **3)** _____

2) _____ **4)** _____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

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

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

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

Do you have any blood relatives with:

Cancer	Y / N	Who?
Hypertension	Y / N	Who?
Cardiovascular	Y / N	Who?
Diabetes	Y / N	Who?
Arthritis	Y / N	Who?

CURRENT HEALTH CONDITION

Purpose of this appointment: _____

When did this happen? _____

What were you doing? _____

What do you do to make the problem better? _____

What makes your problem worse? _____

Has this happened before? Y / N **If yes, how often?** _____

Have you seen another doctor for this problem? Y / N **If yes, medical or chiropractic?** _____

Name of Doctor: _____ **Type of treatment:** _____

Do you have any blood relatives with similar symptoms? Y / N **If yes, who?** _____

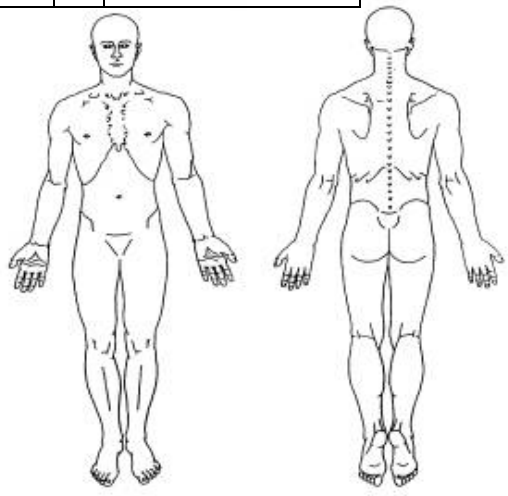
Other complaints: _____

HEALTH QUESTIONNAIRE

If you have ever had a listed condition in the past or are presently troubled by a particular condition, please check it.

	Condition		Condition		Condition		Condition
	Neck Pain		Rapid heart beat		Heart attack		Abdominal pain
	Shoulder Pain		Chest pains		Aneurysm		Constipation
	Pain in arm/elbow		Heartburn/indigestion		Angina		Diabetes
	Hand pain		Excessive thirst		High blood pressure		Epilepsy
	Wrist pain		Abnormal weight loss		Stroke		Ulcer
	Upper back pain		Abnormal weight gain		Asthma		Blood disorder
	Low back pain		Chronic cough		Allergies		Liver disorder
	Pain in upper leg/hip		Chronic sinusitis		Cancer		Skin problems
	Pain in lower leg/knee		General fatigue		Tumor		Depression
	Pain in ankle or foot		Menstrual problems		Arthritis		Difficulty swallowing
	Jaw pain		Endometriosis		Headaches		Numbness/tingling
	Swelling/stiffness in joints		PMS		Tinnitus (ear noises)		HIV/AIDS
	Muscle Weakness		Kidney/bladder problems		Visual disturbances		
	Fainting		Dizziness		Colitis		
	Convulsions		Bladder infection		Gallbladder problems		

Locate and document your pain on the body diagram:



What is your pain right now?

No Pain _____ Worst Possible Pain

1 2 3 4 5 6 7 8 9 10

What is your type of pain?

□ Ache □ Numbing □ Shooting □ Tingling/Pins

Continued …

PERMISSION REQUEST WRITTEN ACKNOWLEDGEMENT

- I authorize the doctor or his staff to render care as deemed appropriate for me and/or my child.
- I authorize Landen Chiropractic to release and/or request records to or from other providers as necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?

_____ _____

Patient/Parent Signature Date

PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

I have received the Landen Chiropractic Notice of Privacy Practices.

_____ _____

Patient/Parent Signature Date

Documentation of Good Faith Effort

□ Attempted to distribute the Notice of Privacy Practices to the patient, but the patient declined to acknowledge the receipt of the Notice of Privacy Practices.

□ Patient stated they had already received the Privacy Notice.

□ Patient directed our clinic's website to view the Notice of Privacy Practices.

□ The Notice of Privacy Practices was mailed to the patient.

Witness: _____