

NAME: _____

DATE: _____

Constitutional:

| | YES | NO |
|----------------------|-----|-----|
| Weight Loss/Gain | ___ | ___ |
| Energy Level Problem | ___ | ___ |
| Loss of Sleeping | ___ | ___ |
| Night Sweats | ___ | ___ |
| Fever | ___ | ___ |
| Chills | ___ | ___ |

Cardiovascular:

| | YES | NO |
|-----------------------|-----|-----|
| High Blood Pressure | ___ | ___ |
| Low Blood Pressure | ___ | ___ |
| Aortic Aneurysm | ___ | ___ |
| Heart Disease | ___ | ___ |
| Heart Attack | ___ | ___ |
| Pacemaker | ___ | ___ |
| Swelling of Extremity | ___ | ___ |

Musculoskeletal:

| | YES | NO |
|-----------------|-----|-----|
| Gout | ___ | ___ |
| Arthritis | ___ | ___ |
| Joint Stiffness | ___ | ___ |
| Muscle Weakness | ___ | ___ |
| Osteoporosis | ___ | ___ |
| Broken Bones | ___ | ___ |
| Joints Replaced | ___ | ___ |

Endocrine:

| | YES | NO |
|-----------------------|-----|-----|
| Thyroid Disease | ___ | ___ |
| Diabetes | ___ | ___ |
| Hair Loss | ___ | ___ |
| Heat/Cold Intolerance | ___ | ___ |

Psychiatric:

| | YES | NO |
|------------------|-----|-----|
| Depression | ___ | ___ |
| Anxiety Disorder | ___ | ___ |
| Unusual Stress | ___ | ___ |
| Mood Swings | ___ | ___ |

Ear/Nose/Throat:

| | YES | NO |
|-----------------------|-----|-----|
| Hearing Loss | ___ | ___ |
| Ringing in Ears | ___ | ___ |
| Sinus Infection | ___ | ___ |
| Nosebleeds | ___ | ___ |
| Sore Throat | ___ | ___ |
| Difficulty Swallowing | ___ | ___ |
| Bleeding Gums | ___ | ___ |
| Enlarged Glands | ___ | ___ |
| Loss of Taste | ___ | ___ |

Respiratory:

| | YES | NO |
|---------------------|-----|-----|
| Asthma | ___ | ___ |
| Emphysema | ___ | ___ |
| Shortness of Breath | ___ | ___ |
| Cough/Wheezing | ___ | ___ |
| Sleep Apnea | ___ | ___ |

Genitourinary:

| | YES | NO |
|------------------------|-----|-----|
| Kidney Disease | ___ | ___ |
| Kidney Stone | ___ | ___ |
| Pain/Burning Urination | ___ | ___ |
| Frequent Urination | ___ | ___ |
| Prostate Problems | ___ | ___ |

Neurological:

| | YES | NO |
|---------------------|-----|-----|
| Stroke | ___ | ___ |
| Seizures | ___ | ___ |
| Dizziness | ___ | ___ |
| Head Injury | ___ | ___ |
| Numbness | ___ | ___ |
| Severe Headaches | ___ | ___ |
| Pinched Nerves | ___ | ___ |
| Parkinson's disease | ___ | ___ |

Allergic/Immunologic:

| | YES | NO |
|-----------------|-----|-----|
| Hives | ___ | ___ |
| Allergy Shots | ___ | ___ |
| Steroid Shots | ___ | ___ |
| HIV/AIDS | ___ | ___ |
| Immune Disorder | ___ | ___ |

Eyes:

| | YES | NO |
|----------------|-----|-----|
| Glaucoma | ___ | ___ |
| Double Vision | ___ | ___ |
| Blurred Vision | ___ | ___ |
| Pain | ___ | ___ |

Gastrointestinal:

| | YES | NO |
|----------------------|-----|-----|
| Poor Appetite | ___ | ___ |
| Nausea/Vomiting | ___ | ___ |
| Ulcers | ___ | ___ |
| Gallbladder Problems | ___ | ___ |
| Bowel Problems | ___ | ___ |
| Constipation | ___ | ___ |
| Diarrhea | ___ | ___ |
| Bloody Stools | ___ | ___ |
| Liver Problems | ___ | ___ |

Skin:

| | YES | NO |
|--------------|-----|-----|
| Skin Ulcers | ___ | ___ |
| Skin Disease | ___ | ___ |
| Eczema | ___ | ___ |
| Psoriasis | ___ | ___ |
| Rashes | ___ | ___ |

Hematologic/Lymphatic:

| | YES | NO |
|---------------|-----|-----|
| Cancer | ___ | ___ |
| Blood Clots | ___ | ___ |
| Hepatitis | ___ | ___ |
| Bruise Easily | ___ | ___ |

Women Only:

| | YES | NO |
|------------------------|-----|-----|
| Are you pregnant | ___ | ___ |
| Lumps in Breasts | ___ | ___ |
| Dimpling in Breasts | ___ | ___ |
| Breast Pain | ___ | ___ |
| Irregular Menstruation | ___ | ___ |
| Painful Menstruation | ___ | ___ |
| Menopausal | ___ | ___ |

Patient Health History Update

Patient Name _____

Address _____

City _____ State _____ Zip Code _____

Primary Phone _____ Mobile Phone _____

Home email _____

****Your e-mail address will not be used for Spam but will allow you access to an online portal to view your records and allow us to communicate to you personalized health information.**

Preferred Contact Method (check one) Primary Phone Mobile Phone

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) _____ | |

Has any doctor diagnosed you with Hypertension (High Blood Pressure)? Yes No

Has any doctor diagnosed you with Diabetes? 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

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

Verification Question (Choose only one question by checking 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.******

Briefly list why you are here today: _____

Date of Injury: _____ Date Symptoms First Appeared: _____

Have you ever had the same condition: Yes No If yes, when? _____

List other practitioners seen for this injury/condition: _____

Social History/Habits:

Sleep _____ hours Coffee/Tea _____ cups/day Alcohol _____ drinks/week Soda _____ drinks/day

Water _____ glasses/day Exercise _____ /week Recreational Drug Use: ___ None ___ Past ___ Present

Physical Stress Level: ___ Mild ___ Moderate ___ High

Emotional Stress Level: ___ Mild ___ Moderate ___ High

Date: _____

Patient's Signature

Guardian's Signature