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