HEALTH HISTORY INFORMATION *(Please Print)* DATE: ________

Name: ______________________ SS# ____________ Birth Date: ________ SEX: ☐M ☐F
Street: ______________________ City: ____________ State: ______ Zip: __________
Phone#1 ______________________ **Phone#2** ______________________
E-Mail #1: ______________________ **E-Mail #2**: ______________________
Marital Status: Single // Married Emergency Contact: ______________ Phone# __________
Employer: ______________________ Occupation: ______________ Phone# __________
Address: ______________________ City: ____________ State: ________ Zip: ________

Name of the Insurance for at fault Party: ______________________ Claim# __________
Name of your Auto Insurance Company. ______________________ Claim# __________
Name of your Health Insurance Co. ______________________ Policy# __________
(If this is Work Comp) Date of Injury:__________ Work Comp Claim # ______________

PRESENT COMPLAINTS: **Date of Injury**: ________ **Was Accident Reported?** ☐Yes ☐ No
Please List your Symptoms: 1)______________________ 2)______________________
3)______________________ 4)______________________ 5)______________________

Indicate current pain levels you have been experiencing

(No Pain) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Worst Pain Ever)

Type of Pain / Discomfort (Circle All that apply)
Shooting / Aching / Burning / Dull / Sharp / Throbbing / Cramping / Numbness / Stiff
Other: ____

MEDICAL HISTORY

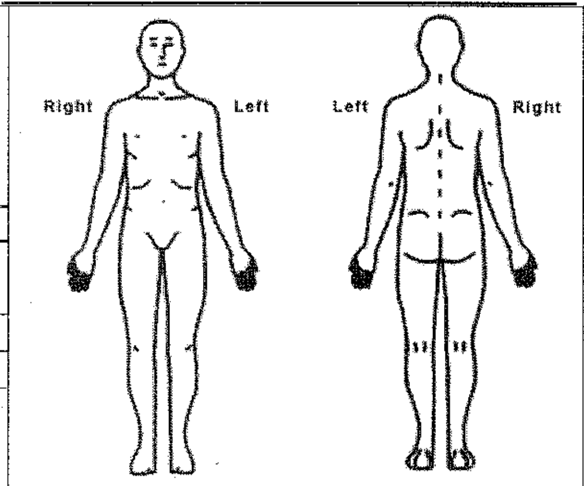
(CIRCLE ANY WHICH APPLY TO YOU)
Hypertension / Osteoporosis / Convulsions
Multiple Sclerosis / Diabetes / Epilepsy / Cancer
Aids/HIV / Asthma / Hepatitis / Stroke / Arthritis
Tuberculosis / Concussions / Anemia / Pacemaker
Other: ______________________________

List any Medication or Supplements you are taking:
____

List any Surgeries or Broken Bones: ______________
____

Are you pregnant or think you might be: **YES / NO**
Start Date of last menstrual period? __________

MARK WHERE DISCOMFORT BOTHERS YOU



Other Information: ____
____

Habits: Smoke / Coffee / Alcohol / Caffeine Drinks **Amount**: ______________________
Exercise Frequency: None / Seldom / Weekly / Daily **Type**: ______________________

I attest that the above information is true and complete to the best of my knowledge & I give permission for the office or its designated representative to follow up with me related to my treatment / care / appointments or any bills by any and all means including but not limited to: Phone, Fax, Text, Email, etc.
Signature of patient: ______________________________

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