CONFIDENTIAL HEALTH HISTORY

Please fill out the following information to the best of your knowledge to help us understand your condition fully and determine if we can help you. All information provided is considered confidential and will only be released by written consent of patient or guardian of patient. Thank you for entrusting us with your care.

NAME________________________________ MALE/FEMALE DATE____________

ADDRESS__________________________CITY__________STATE_____ZIP__________

AGE____ DATE OF BIRTH________ SOCIAL SECURITY #____________ MARTIAL STATUS: S/M/D/W

#CHILDREN_____ HOME/CELL#__________________ EMAIL______________________

EMPLOYER__________________ OCCUPATION____________ WORK #___________

SPOUSE/GUARDIAN___________________________ CELL/WORK #______________

EMERGENCY CONTACT_________________________ CELL/WORK #______________

HOW DID YOU HEAR ABOUT OUR OFFICE?__________________________________

METHOD OF PAYMENT

(circle which applies) BCBS Cigna United Medicare Auto Accident Cash Other_______

POLICY HOLDER___________________ RELATIONSHIP________ DATE OF BIRTH_________

ADDRESS__________________________CITY__________STATE_____ZIP__________

GENERAL HEALTH HISTORY

HEIGHT_____ WEIGHT______ PRIMARY CARE PHYSICIAN_______________________

HAVE YOU BEEN DIAGNOSED WITH OR SUFFER FROM ANY OF THE FOLLOWING? ("x" what applies)

__HIGH BLOOD PRESSURE
__LOW BLOOD PRESSURE
__HEART TROUBLE
__DIABETES
__PACEMAKER
__TIA/STROKE
__ANEMIA
__ASTHMA
__HIV/AIDS
__HIGH CHOLESTEROL
__FIBROMYALGIA
__NEUROPATHY
__OSTEOPOROSIS
__OSTEOPENIA
__MUSCLE PAIN
__JOINT PAIN
__NERVE PAIN
__PREGNANCY (due date)__________
__SCIATICA
__NECK PAIN
__HEADACHES
__LOW BACK PAIN
__OTHER_______

DO YOU SMOKE OR USE TOBACCO(packs/day)?_______ DO YOU EXERCISES(days/week)?_______

ACCIDENTS/INJURIES____

SURGERIES/OPERATIONS____

CURRENT MEDICATIONS____

RESENT IMAGING (Xray, MRI, CT scan) within last year. Please provide date and body area:

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