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# _____

(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

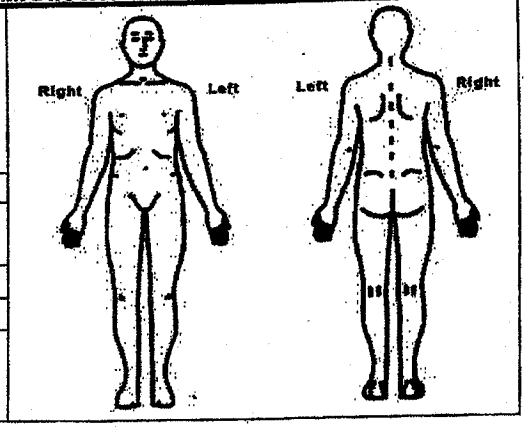
(CIRCLE ANY WHICH APPLY TO YOU)
Hypertension / Osteoporosis / Convulsions
Multiple Sclerosis / Diabetes / Epilepsy / Cancer
Aids/HIV / Asthma / Hepatitis / Stroke / Arthritis
Tuberculosis / Concussions / Anemia / Pacemaker
Other: _____

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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