HEALTH HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to aid us in providing quality health care. Please complete the questions as accurately as possible (print legibly). This questionnaire and your entire clinical record are strictly confidential and will not be release to anyone without your written consent/signature.

Date: Patient Name:		DOB: Sex:	Age:
Parent if Patient is a Minor:		Race: Caucasian, African American, Asian, Hispanic, Other	
Patient's Social Security #:		Marital Status: S M W D Sep	Rec'd Privacy Notice: Y / N
Home Address:	City:	State:	Zip:
Telephone Numbers: Home:	Work:	Cell:	
Employer's Name:		Occupation:	
Employer's Address:	City:	State:	Zip:
Spouse Name:		Spouse's Employer:	
Family Doctor:	City:	Telephone Number:	
Name of Emergency Contact (not living with you)			
Emergency Contact Home Phone #:		Work #:	
Referred By:			
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES			
Name:	Relationship:	Telephone #:	
Address:	City:	State:	Zip:
Insurance Company:		Claim Address:	
Subscriber's Name:	Subscriber's DOB:	SSN:	
Insurance ID #:		Employer Name:	
Secondary Insurance:		Secondary Ins Claim Address:	
Secondary Ins Subscriber's Name & ID #:	DOB:	SSN:	
WORKER'S COMPENSATION INFORMATION:			
Were you injured on the job? YES / NO		Have you informed your employer? YES / NO	
Date of injury:			
LIBILITY INFORMATION:			
Date of Accident:		Name of Attorney:	
Auto Insurance Carrier:		Claim Number:	

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim or other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts Assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information). I understand that I am responsible for any amount not covered by my insurance company.

Signature: Date:

HISTORY OF PRESENT ILLNESS

Main problem:
____
____
____
____

When did your symptoms start? ____

What started your symptoms?
______INJURY ___________________NORMAL DAILY LIFE _____________UNKNOWN

DATE OF INJURY: ____________________ How and what caused injury?
____
____

Where did the injury happen?____

Have you ever had this problem before? YES / NO If yes, When? _____________________________
How often is your pain present? _______Occasional _______Intermittent _________Constant

Rate your pain on a scale of 1 to 10: ________

What makes the pain worse?____

What makes the pain better? ____

Have you been treated before? ___ Yes ___ No When __________By Whom? ________________

Have you had physical therapy? ___Yes ___ No Where? ____________________________________

Have you had any medicine for this? ___Yes ___No
If Yes, what medicine? ____
____
____

Have you had any of the following tests?	Yes	No	When?
X-rays	___	___	_______________
CT Scan	___	___	_______________
Bone Scan	___	___	_______________
MRI	___	___	_______________
EMG	___	___	_______________
Myelogram	___	___	_______________

If Yes, did you bring them or the report? ___ ___

If you did not bring them please let the receptionist know.

Please check if the condition applies. General Health Good__ Fair__ Bad__

Fever ___
Chills ___
Excessive Fatigue ___
Exercise Intolerance ___
Night Sweats ___

Head, Eyes, Ears, Nose & Throat

Headaches ___
Head Injury ___
Concussion ___
Vision Changes ___
Eye Pain ___
Glaucoma ___
Cataracts ___
Glasses ___
Contacts ___
Dentures ___
Partial Plates ___
Hearing Changes ___
Hearing Aid ___
Ear Pain ___
Nose Bleeds ___
Sinus Problems ___
Hay Fever ___
Dizziness ___
Allergies ___
Swallowing Problems ___
Neck Stiffness ___
Hoarseness ___
Enlarged Thyroid ___
Neck Pain ___

GASTROINTESTINAL

Belching or Gas ___
Vomiting ___
Nausea ___
Poor Appetite ___
Constipation ___
Unexplained Wt. Loss ___
Food Intolerance ___
Diarrhea ___
Rectal Bleeding ___
Bloating ___
Vomiting Blood ___
Change in Bowel Habit ___

MUSCULOSKELETAL

Arthritis ___
Neck Pain ___
Weakness ___
Swollen Joints ___
Deformities ___
Back Pain ___
Gout ___
Amputations ___
Multiple Sclerosis ___
Dominant Hand R or L

CHILDHOOD DISEASES

Measles ___
Mumps ___
Chicken Pox ___
Diptheria ___

RESPIRATORY

Shortness of Breath ___
Wheezing ___
Tuberculosis ___
Cough ___
Bronchitis ___
Asthma ___
Pneumonia ___
Coughing Blood ___
Emphysema ___

CARDIOVASCULAR

Chest Pain ___
Swollen Ankles ___
High Cholesterol ___
Stroke ___
Shortness of Breath
at Rest ___
With Activity ___
Heart Attack ___
Poor Circulation ___
Blood Clots ___
Heart Failure ___
Irregular Heartbeat ___
Low Blood Pressure ___
High Blood Pressure ___
Phlebitis ___

GENITOURINARY

Frequent Urination ___
Painful Urination ___
Vaginal Discharge ___
Blood in Urine ___
Prostate Problems ___
Unable to control Kidneys ___
Difficulty Starting Urine ___
Testicular Pain ___
Erectile Dysfunction ___
Pregnant Now? ___
Date of Last Period _________

MUSCULOSKELETAL CONT.

Sciatica ___
Spine Surgery ___
Injuries to Spine ___
Bursitis ___
Polio ___
Previous Fractures ___
____

SKIN

Color Changes
In Lesions ___
Changes in Nail
Color ___
Varicose Veins ___
Hives ___
Moles ___
Itching ___
Warts ___
Eczema ___
Easy Bruising ___
Dry Skin ___
Rashes ___
Scars ___

NEUROLOGIC

Seizures ___
Paralysis ___
Fainting ___
Vertigo ___
Dizziness ___
Behavioral Changes ___
Memory Loss ___
Disorientation ___
Speech/Language ___
Dysfunction ___

ENDOCRINE/HEMATOLOGIC LYMPHATIC

High Blood Sugar ___
Low Blood Sugar ___
Anemia ___
Bleeding Disorder ___
Thyroid Disease ___
Cancer ___
Blood Transfusion ___
When?____________________
HIV ___
Excess Thirst ___
Growth of Hair ___
Increased Appetite ___

PSYCHIATRIC

Nervous Breakdown ___
Anxiety ___
Sleep Disturbance ___
Hallucinations ___
Depression ___
Suicidal ___
Other ____________________
____
____

TURN OVER

PAST MEDICAL HISTORY

Please check if condition applies.

Diabetes ___
Heart Disease ___
High Blood Pressure ___
Ulcers ___
Stroke ___
Anemia ___
Seizures ___
Cancer ___
Tuberculosis ___
Bleeding Disorder ___
Skin Disease ___
Chest Pain ___
Acid Reflux ___
Lung Disease ___
Thyroid Disease ___
Depression ___
Alcoholism ___

SOCIAL HISTORY

Marital Status
Married__Single__Divorced__Widowed__
# of Children___# still in home___
Are you working? Yes__ No__
Where do you work?___________________
Do You Smoke? Yes__ No__
Have in the Past? Yes__ No__
Packs Per Day____for ______Years
Do You Use Smokeless Tobacco? Yes / No
Do You Drink Alcohol? Yes / No
If Yes, what and how much?____________
Do you or have you used street drugs?
Yes / No What?_____________________

PAST SURGERIES: (PLEASE LIST ALL SURGERIES YOU HAVE HAD)

DATE: SURGERY/TYPE YEAR

____
____
____
____
____

FAMILY HISTORY:	**AGE**	**Living? Yes or No**	**Serious Illness or Cause of Death**
FATHER	___	________	__________________________
MOTHER	___	________	__________________________
SIBLINGS	___	________	__________________________
	___	________	__________________________
	___	________	__________________________
	___	________	__________________________
	___	________	__________________________

CURRENT MEDICATIONS:

NAME STRENGTH (MG) TIMES PER DAY

____
____
____
____
____
____
____
____
____
____

ALLERGIES TO MEDICATIONS: (PLEASE LIST THE DRUG AND THE REACTION OR NONE)

____
____
____
____