PATIENT HEALTH HISTORY UPDATE

Name: _____ Today's Date ___ /___ /___

Address: _____

City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Email: _____

Date of Birth: ___ /___ /___ Emergency Contact NAME & Number: _____

Marital Status: *(circle one)* *Single* *Married* *Divorced* *Widowed* *Separated*

Employment Status: *(circle one)* *Employed* *FT Student* *PT Student* *Retired* *Self Employed* *Unemployed*

Occupation: _____ Insurance Company: _____

Circle your health concerns: Neck Pain Shoulder Pain Sprain/Strain Low Back Pain

Mid Back Pain Upper Back Pain Headaches/Migraines

Other: _____

Are your health concerns shown above related to an accident or an injury? *Yes* *No*

If yes, please explain_____

_____

Has a doctor diagnosed you with currently having high blood pressure? *Yes* *No*

Has any doctor diagnosed you with Diabetes presently? *Yes* *No*

If yes, what type? *TYPE I* *TYPE II* *Adult onset*

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9%? *Yes* *No* *Not Sure*

Have you had an X-ray, CT scan or MRI of your low back in the past 28 days? Yes No

Do you currently use tobacco products? Yes No Former

Current medications, vitamins and dosage. *If there are no current medications, check here:* ___

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

List any known medication allergies you have had. *If no allergies are known, check here*: ____

1) _____ 3) _____
2) _____ 4) _____

Other allergies:_____

List any surgeries you have had: _____

Alcohol use? (circle one)	None	Casual	Moderate	Heavy
Caffeine use?	None	Light	Moderate	Heavy
Exercise?	Never	Daily	Weekly	Walks
Drugs?	None	Prescription	Recreational	Addiction

I understand that treatment of the condition(s) I present to my doctor may require additional services provided by my doctor for my treatment. I understand that I am financially responsible for all services used to treat my condition(s). Additional services may include, but are not limited to, exams, extremities, muscle stimulation, ultra sound, decompression and muscle therapy.

Signature of Patient: _____