PATIENT HEALTH HISTORY

Name _____ **Called Name** _____ **DOB** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home # _____ **Cell #** _____ **Work #** _____

1 ***Email** _____ **SSN** _____

**We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice.*

Marital Status: (Circle) S M D W **Name of Spouse** _____

Ins. Subscriber's Name (check if same ❑) _____ **Subscriber's DOB** _____

Emergency Contact/Relationship _____ **Emergency Phone** _____

Chief Complaint _____

WHEN did CURRENT symptoms appear: _____

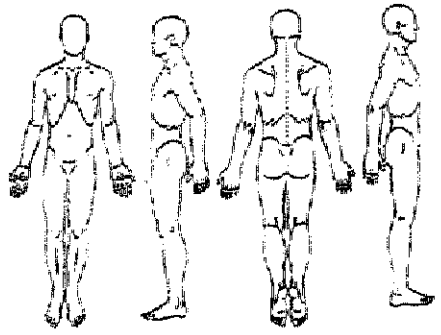
HOW did CURRENT symptoms begin? _____

2 **Location** ❑ Left ❑ Right ❑ Middle

Indicate location(s) of pain on the chart below

Pain Scale 0 1 2 3 4 5 6 7 8 9 10

No Pain Minimal Mild Moderate Severe Unbearable



NATURE

1. ❑ Deep ❑ Superficial
2. ❑ Gradual ❑ Sudden
3. ❑ Localized ❑ Shooting/Radiating

→ If Shooting/Radiating, choose:
❑ Head ❑ Neck ❑ Mid back ❑ Shoulder ❑ Arm ❑ Hand
❑ Low Back ❑ Groin ❑ Hip ❑ Thigh ❑ Knee ❑ Calf ❑ Foot

3 4. ❑ Sharp Pain ❑ Sore/Tender ❑ Throbbing ❑ Evening ❑ Nausea
❑ Stabbing Pain ❑ Numb ❑ Knots ❑ Cracking ❑ Vomiting
❑ Dull Pain ❑ Tingling ❑ Spasm ❑ Dizziness
❑ Ache ❑ Burning ❑ Weak ❑ Lightheaded
❑ Stiff/Tight ❑ Pressure ❑ Morning ❑ Blurred Vision

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4 **FREQUENCY** ❑ 76-100% of day ❑ 51-75% of day ❑ 26-50% of day ❑ 0-25% of day

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MAKES PAIN WORSE

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❑ Bend Forward	❑ Walk	❑ Sleep	❑ Breathe	❑ Exercise, Sports
❑ Bend Backwards	❑ Sit	❑ Lift	❑ Cough	❑ In/Out of Car/Bed
❑ Bend Sideways	❑ Stand	❑ Reach	❑ Sneeze	❑ Carry Objects
❑ Twist/Turn	❑ Stand Up	❑ Yard Work	❑ Urinate	❑ Inactivity
❑ Look Up	❑ Sit Down	❑ Heat	❑ Computer	❑ Other _____
❑ Look Down	❑ Socks, Shoes on	❑ Ice	❑ Housework	_____
❑ Change Positions	❑ Drive	❑ Weather Changes		

MAKES PAIN BETTER

❑ Nothing	❑ Exercise	❑ Look Up	❑ Sit	❑ Inactivity
❑ Bend Forward	❑ Heat	❑ Look Down	❑ Stand	❑ Pain Meds
❑ Bend Backwards	❑ Ice	❑ Walk	❑ Sleep	

6 ALLERGIES

- ☐ None
- ☐ Animals
- ☐ Antibiotics
- ☐ Dairy
- ☐ Eggs
- ☐ Gluten
- ☐ Pain Meds
- ☐ Penicillin
- ☐ Seasonal
- ☐ Shellfish
- ☐ Sulfa
- ☐ Other _____

7 SURGERIES

- ☐ None
- ☐ Appendectomy
- ☐ Bladder
- ☐ Brain
- ☐ Carotid Artery
- ☐ Carpal Tunnel
- ☐ Cataracts
- ☐ Cesarean
- ☐ Disc _____
- ☐ Gallbladder
- ☐ Gastric Bypass
- ☐ Heart Bypass
- ☐ Hernia(inguinal/umbilical)
- ☐ Hip Replacement
- ☐ Hysterectomy (partial/total)
- ☐ Kidney Stones
- ☐ Knee (ligament/ meniscus)
- ☐ Knee Replacement
- ☐ Mastectomy
- ☐ Pacemaker
- ☐ Prostate
- ☐ Rotator Cuff
- ☐ Shoulder
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Vasectomy
- ☐ Other _____

8 MEDICAL HISTORY

- ☐ None
- ☐ Acid Reflux
- ☐ Alzheimer's
- ☐ Anxiety
- ☐ Aneurysm
- ☐ Asthma
- ☐ Arthritis, Spine
- ☐ Arthritis, Hip, Knees
- ☐ Blood Clots
- ☐ Cancer
- ☐ Carpal Tunnel
- ☐ Cataracts
- ☐ Carotid Artery Stenosis
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diabetic Neuropathy
- ☐ Disc Bulging
- ☐ Disc Herniation
- ☐ Disc Degeneration
- ☐ Enlarged Prostate/BPH
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Flat Feet
- ☐ Gall Stones
- ☐ Gout
- ☐ Headaches
- ☐ Heart Attack
- ☐ Hernia (inguinal/ umbilical)
- ☐ High BP
- ☐ High Cholesterol
- ☐ Irritable Bowel Disease
- ☐ Kidney Stones
- ☐ Leukemia
- ☐ Lyme Disease
- ☐ Menopause
- ☐ Multiple Sclerosis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Polio
- ☐ PTSD
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Seizures
- ☐ Shingles
- ☐ Spinal Fracture _____
- ☐ Spinal Stenosis
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Vertigo
- ☐ Other _____

9 FAMILY HISTORY

	Mother	Father	Sibling
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Heart Problems	☐	☐	☐
High Blood Pressure	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Stroke	☐	☐	☐

10 MEDICATIONS & PURPOSE *(*(If you have a list, please give to receptionist)*

_____ _____

_____ _____

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Missed school/work for this condition. ☐ No ☐ Yes Any restrictions? ☐ None If Yes explain: _____

Were other physicians consulted for this condition? ☐ No ☐ Yes If yes, Dr(s) _____

Diagnosis: ☐ No ☐ Yes: _____

Received any? ☐ X-rays ☐ MRI ☐ CT **Treatment:** ☐ No ☐ Yes: If yes, what kind _____

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Have you felt down, depressed or hopeless in the last 2 weeks?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

How often do you drink alcohol? ☐ Never ☐ Monthly or less ☐ 2-4 x/month ☐ 2-3 x/week ☐ 4+ x/week

How often do you smoke or use tobacco?
☐ Never ☐ Former ☐ Social ☐ < ½ pack/day ☐ 1 pack/day ☐ 1-2 pack/day ☐ 2+ pack/day ☐ Chew tobacco/Snuff

How often do you exercise? ☐ None ☐ Occasionally ☐ Regularly ☐ Daily

Position(s) you usually sleep in: ☐ Back ☐ Sides ☐ Stomach

Number of pillows behind head while sleeping: _____

WORK ACTIVITY

Status: ❑ Employed ❑ Unemployed ❑ Retired ❑ Homemaker ❑ Student ❑ Disabled

13 **Job Lifting Requirements:** ❑ <10 lbs ❑ <20 lbs ❑ <50 lbs ❑ >50 lbs

Lifting Frequency: ❑ 0-25% ❑ 26-50% ❑ 51-75% ❑ 76-100%

Most Frequent Work positions: ❑ Sit ❑ Stand ❑ Walk ❑ Lift/Bend ❑ Twist ❑ Reach ❑ Drive

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REVIEW OF SYSTEMS - Are you CURRENTLY experiencing any problems in the following areas?

14

General Symptoms
- ❑ None
- ❑ Fever
- ❑ Chills
- ❑ Night Sweats
- ❑ Fatigue
- ❑ Insomnia
- ❑ Headache
- ❑ Recent Unexplained Weight Loss

Respiratory
- ❑ None
- ❑ Coughing Up Blood
- ❑ Difficulty Breathing
- ❑ Wheezing

Neurological
- ❑ None
- ❑ Restless Legs
- ❑ Seizures
- ❑ Tremors
- ❑ Slurred Speech
- ❑ Fainting
- ❑ Loss of Sensation
- ❑ Dizziness
- ❑ Vertigo
- ❑ Paralysis
- ❑ Facial Weakness

Eyes, Ears, Nose, Throat
- ❑ None
- ❑ Ears Ringing
- ❑ Blurred Vision
- ❑ Difficulty Swallowing
- ❑ Loss of Smell, Taste

Muscle & Joint
- ❑ None
- ❑ Joint, Spinal Pain
- ❑ Spinal Fracture
- ❑ Muscle Weakness
- ❑ Muscle Spasms
- ❑ TMJ Problems
- ❑ Joint Stiffness
- ❑ Swollen/Red Joints

Psychiatric
- ❑ None
- ❑ Anxiety
- ❑ Memory Loss
- ❑ Panic Attacks
- ❑ Depression
- ❑ Suicidal Thoughts

Genitourinary
- ❑ None
- ❑ Difficulty Urinating
- ❑ Bed Wetting
- ❑ Bladder Problems
- ❑ Blood In Urine
- ❑ Frequent Urination
- ❑ Pain During Urination
- ❑ Loss of Bladder Control

Female
- ❑ None
- ❑ Currently Pregnant? Y / N
- If yes, # of weeks _____
- ❑ Hot Flashes
- ❑ Menopausal

Gastrointestinal
- ❑ None
- ❑ Vomiting
- ❑ Constipation
- ❑ Bloody Stools
- ❑ Indigestion
- ❑ Nausea
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Loss of Bowel Control

Cardiovascular
- ❑ None
- ❑ Chest Pain
- ❑ Shortness of Breath With Exertion
- ❑ Chest Heaviness
- ❑ Pain Radiating to Jaw, Arms

Endocrine
- ❑ None
- ❑ Heat/Cold Intolerance
- ❑ Excessive Thirst
- ❑ High/Low Blood Sugar
- ❑ Decreased Appetite

I certify to the best of my knowledge that the above information is complete and accurate. If my condition needs to be co-managed with my PCP and/or specialist, I give authorization to Dr. Noll to contact my physician.

I understand that my insurance policy is a contract between myself and my insurance company, NOT BETWEEN THIS OFFICE AND MY INSURANCE COMPANY. I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to my current insurance company or its administrator.

I understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, deductibles and services not covered or deemed not medically necessary by my insurance company.

We request that all of the charges be paid at time of service or the last visit of week. Our bank charges Noll Chiropractic $40 fee if your check is returned for insufficient funds. If my account becomes assigned to a collection agency, I agree to pay collection agency fees of 25%, court costs, and attorney fees. I understand that all accounts with a balance over 30 days will be assessed a 1.5 percent late charge per month on the unpaid monthly balance.

_____ _____

PATIENT/ GUARDIAN (SEAL) **DATE**