Family Chiropractic & Massage Of Charleston

Patient Health History

Patient Title: (check one) ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss. ❑ Dr. ❑ Prof. ❑ Rev.

First Name ______________________ Preferred Name ______________________

Last Name ______________________ Middle Name ________________ Suffix ________

Date of Birth [ ] Age ______ Gender (check one) ❑ Male ❑ Female ❑ Unspecified

SSN ______________________ Marital Status (check one) ❑ Single ❑ Married ❑ Other

Address ____

City ______________________________ State ________ Zip Code ____________

Home Phone ______________________ Mobile Phone ______________________

Home Email ______________________ Work email ______________________

Insured Name ______________________ Insured DOB ______________________

Occupation ____

Spouse Name ______________________ Spouse Occupation ______________________

How did you hear about us? ____

(By providing my email I authorize my doctor to contact me via the email address(es) provided.)

Which email address would you like us to use to communicate with you? (check one) ❑ Home ❑ Work

Contact Method (check one)

❑ Home Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Employment Status (check one)

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race (check one)

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑ Samoan	❑ Guamanian or Chamorro	❑ Other__________	❑ I choose not to specify

Multi-Racial (check one) ❑ Yes ❑ No ❑ Unknown

Ethnicity (check one) ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language (check one)

❑ English	❑ Spanish	❑ American Sign Language		❑ Chinese	❑ French	❑ German
❑ Taglong	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish	
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi	
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify		

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

no interest — Very interested

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, Describe: ______________

____

Has any doctor diagnoses you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes:

Current medications, including frequency and dosage if known. If there are no current medications, check here: ☐

		Start Date			Start Date
1)			5)		
2)			6)		
3)			7)		
4)			8)		

List any known allergies you have had to any medications.If no allergies, check here: ☐

1) ______________________ 3) ______________________

2) ______________________ 4) ______________________

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

What is your major compaint? ______________________

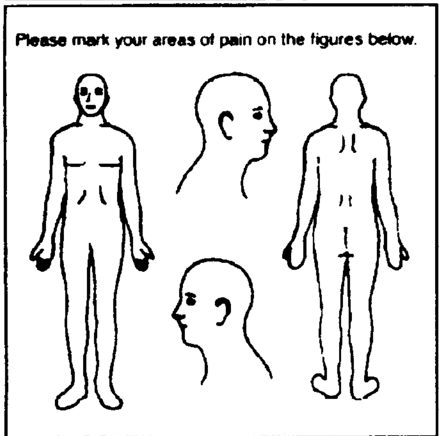
Other complaints? ______________________

How long have you had this condition? __________ Have you had this or similar condition in past? __________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐Constant ☐Comes and goes

Female: Are you pregnant at this time? ☐ Yes ☐ No Due Date ______________

Rate your pain from 0 -10
(10 being worst)
0 1 2 3 4 5 6 7 8 9 10



CHECK ALL THAT APPLY

__Neck Problems
__Shoulder Problem
__Arm problems
__Numbness - Arms
__Pain Between Shoulders
__Low Back Problems
__Leg Problems
__Numbness - Legs
__Loss of Feeling
__Stiff Joints
__Painful Joints
__Restricts Daily Activities
__Restricts Regular Exercise
__Tiredness / Fatigue

__Sore Muscles
__Walking Problems
__Broken Bones
__Muscle Cramps
__Weak Muscles
__Headaches
__Dizziness
__Fainting
__Forgetfulness
__Depression
__Vision Problems
__Ear Pain / Noises
__Ear Infections
__Hearing Loss
__Frequent Colds

__Allergies
__Hay Fever
__Asthma
__Excema
__Shingles
__Nausea
__Poor Digestion
__Ulcers
__Diarrhea
__Constipation
__Kidney Infection
__Menstrual Cramps
__Diabetes
__Blood Pressure
High / Low

Verification Question (choose only one question, then give your answer to that question)

☐ What is the name of your favorite pet? ☐ In what city were you born? ☐ What high school did you attend?
☐ What is your favorite movie? ☐ What is your mother's maiden name? ☐ On what street did you grow up?
☐ What was the make of your first car? ☐ When is your anniversary? ☐ What is your favorite color?

Verification Answer to the chosen question: ______________________
Answers must be at least 6 characters

Signature of Patient ______________________ Date __________

To be performed by clinic staff:

Height: _______ inches Weight: _______ pounds BP: ______ / ______

File Type ______________________

CURRENT DIAGNOSIS CODES

TX Plan ____________ X / WK for
____________ WK's / MO
NMT ________ X / WK

1. __________ **3.** __________

2. __________ **4.** __________