PATIENT HEALTH HISTORY

Today's Date: _____ **Signature of Patient:** _____

Patient Title: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Prof. □ Rev.

First Name: _____ **Middle Name:** _____

Last Name: _____ **Nickname:** _____

Street Address: _____

City, State, Zip: _____

Primary Phone: _____ **Cell Phone:** _____

Email: _____

Preferred contact method: □ Primary Phone □ Cell □ Email

Date of Birth: _____ **Age:** _____ **SSN:** _____

Gender: □ Male □ Female □ Unspecified

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Other

Employment Status: □ FT Student □ PT Student □ Employed □ Self Employed □ Disabled

Patient Employer: _____ **Phone Number:** _____

Employer's Address: _____

Race: (circle one) White Black/African American Hispanic Japenese Korean Chinese
American Indian/ Alaskan Native Korean Filipino Asian Indian
Asian Vietnamese Samoan Guamanian or Chamorro I choose not to specify

Multi-Racial: □ Yes □ No □ Unknown
Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ I choose not to specify

Preferred Language: _____

Minor Patient-Parent/Guardian information:

Name: _____

Address: _____

Phone Number: _____

HEALTH INFORMATION

Do you currently smoke tobacco of any kind? □ Yes □ Former smoker □ Never
If yes, how often do you smoke: □ Everyday □ Occasionally

Current medications, including dosage if known. If no current medications, state none.

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

List any known allergies you have had to any medications. If no known allergies, state none.

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

Briefly state your main chiropractic problem: _____

Has your doctor diagnosed you with Hypertension (high blood pressure) presently? □ Yes □ No

Are you presently diagnosed with Diabetes from any doctor? □ No □ Type I □ Type II

What was your AM blood glucose/A1C reading?_____

Have you had an x-ray or CT scan or MRI of your low back spine in the past year? □ Yes □ No

If yes, Where was this done at?_____

PHYSICIAN INFORMATION

Primary Physican's Name and Clinic: _____

Phone Number: _____

SPOUSAL INFORMATION

Spouse's Name: _____ **Phone Number:** _____

Spouse's SSN: _____ **Spouse's DOB:** _____

INSURANCE INFORMATION

Policy Holder's Name: _____ **DOB:** _____

Policy Holder's Address: _____

Policy Holder's Place of Employment: _____

Billing Information

Note: Co-pay and cash patient balances are due day of service. All statement balances are due within 30 days from statement date.

Sign: _____ Date: _____

Privacy Policy Information

Note: I have been provided with a copy of the Privacy Policies of Davis & Kassmeier Chiropractic to read or to keep.

Sign: _____ Date: _____

EMERGENCY CONTACT

Emergency Contact's Name: _____

Contact Phone: _____

WHO ELSE MAY WE RELEASE YOUR PATIENT HEALTH INFORMATION TO

Name and phone numbers:

1. _____
2. _____