

Patient Health History

Today's Date

Signature of Patient

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

First Name

Nick Name

Last Name

Middle Name

Suffix

Address 1

Address 2

City

State

Zip Code

Primary Phone

Secondary Phone

Mobile Phone

Home email

Work Email

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

Home Work

Contact Method (check one)

Primary Phone Secondary Phone Mobile Phone Home Email Work Email

Date of Birth

Age

Gender (check one)

Male

Female

Unspecified

Marital Status (check one)

Single

Married

Other

SSN

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

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

Tagalog

Vietnamese

Italian

Korean

Russian

Polish

Arabic

Portuguese

Japanese

French Creole

Greek

Hindi

Persian

Urdu

Gujarati

Armenian

I choose not to specify

Verification Question (choose only one question by circling the question, then give the answer to that question)

What is the name of your favorite pet?

In what city were you born?

High school attended?

What is your favorite movie?

What is your mother's maiden name?

On what street did you grow

What was the make of your first car?

When is your anniversary?

What is your favorite color?

Verification Answer to the Chosen question: _____

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

Current medications, including dosage if known.

If there are no current medications, check here:

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

List any known allergies you have had to any medications.

If no allergies are known, check here:

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

Briefly list your main health problems: _____

Has any doctor diagnosed you with Hypertension presently? Yes No If yes, describe: _____

Has any doctor diagnosed 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: _____

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

To be performed by clinic staff:

Height: _____ inches Weight: _____ pounds BP: _____ / _____

DATE: _____

ACCT: _____

PATIENT: _____

PATIENT HISTORY

1. What is your **main complaint**? _____
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

<i>None</i>		<i>Slight</i>		<i>Mild</i>		<i>Moderate</i>		<i>Severe</i>	
1	2	3	4	5	6	7	8	9	10

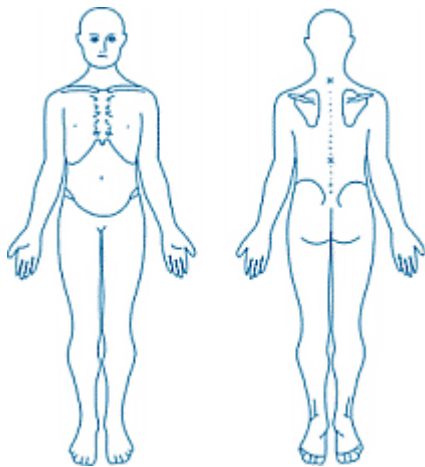
3. On the scale below, please **circle** the **percentage of time** you experience your **main complaint**:

<i>Occasional</i>				<i>Intermittent</i>				<i>Frequent</i>		<i>Constant</i>	
0	10	20	30	40	50	60	70	80	90	100	

4. How **long** have you been experiencing your **main complaint**? _____

5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



6. When do you notice it most? **AM** **PM**
How long does it last? _____Min _____Hrs
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? **Y** **N**
10. I have been hospitalized been treated by another chiropractor
 been treated by another specialty provider
 never received care for this problem
11. Have you lost time from work because of it? **Y** **N**
12. Are you pregnant? **Y** **N**
13. What was the first day of your last menstrual cycle? _____
14. Number of pregnancies? _____ Miscarriages? _____

Do you have **pain** and/or **difficulty** performing and of the following activities: (Check)

- personal care _____
- lifting _____
- reading _____
- concentrating _____
- work _____
- driving _____
- sleeping _____
- recreation _____
- walking _____
- sitting _____
- standing _____
- social life _____

Signature: _____

Date: ___/___/___

Robinson Chiropractic Centers

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1546 E. Algonquin Rd., Algonquin, IL 60102 (847) 458-8444
www.handsdoc.com

Patient Acknowledgement

**For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations**

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice’s Privacy Notice has been provided to me prior to my signing this Consent. The privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (“PHI”) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing the Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The Practice’s “Notice of Privacy Practices” is also provided at the front desk and on the Practice’s web site at (not available yet) I may also request a copy from this office at any time via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative

Date Signed

Relationship

Witness