ridgeview
CHIROPRACTIC

Patient Health History

Today's Date / /

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

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____**Suffix** _____

Address 1 _____

City_____ **State**_____ **Zip Code** _____

Home Phone _____**Work Phone** _____

Mobile Phone _____

Is it ok to leave voice messages on your cell/home phone, text messages on your cell phone, or emails regarding any scheduling conflicts, appointment reminders, or to check on your health condition? Y / N

Email _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided. Email Address (for our monthly newsletter- will not be given to any other businesses)

Who may we thank for referring you in? _____

Date of Birth / / **Primary Insurance Card Holder DOB** / /

Age _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **Spouse Name** _____

Children: YES NO How Many? _____ **SSN** _____

Emergency Contact: _____ **Contact Relationship:** _____

Contact Phone: _____

Employment Status *(check one)*

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

Employer_____ **Occupation**_____

Work Address: _____

_____

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
❑ 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? ❑ 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?

Verification Answer to the Chosen question: _____
Answers must be at least 6 characters.

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*

Alcohol: in past never current 0-1 drink/day 1-2 2-3 3-4 4-5 5+
Caffeinated Drinks: never 0-1/day 1-2 2-3 3-4 4-5 5+
Exercise type and amount: _____
Hours of sleep a night: _____

Please rate your overall health status: (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)
Are you healthier today than you were 5 years ago? _____
What are your health goals?_____
_____

MEDICAL HISTORY
List any surgeries: _____
List any past injuries: _____
Have you been to a chiropractor in the past?_____

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 are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

COMPLAINTS:

Describe your Primary Complaints:

_____
_____
_____
_____
_____
_____

When did the symptoms begin? _____

How often do your symptoms occur? ___Constant ___Frequent ___Intermittent ___Occasional

How would you rate your primary pain usually with 0 being no pain and 10 being the worst pain?
_____

How would you rate your primary pain at its worst with 0 being no pain and 10 being the worst pain?
_____

Are you getting? ___Better ___Worse ___Staying the Same

What makes your symptoms worse? ___Sitting ___Standing ___Walking ___Bending ___Computer Work ___Neck Movement ___Reaching ___Lifting ___Coughing ___Sneezing ___Straining at Stool

What relieves your symptoms? ___Nothing ___Ice ___Heat ___Stretching ___Exercise ___Sitting ___Standing ___Medication

Occupational Stress Level (1-10): (no stress) 1 2 3 4 5 6 7 8 9 10 (very stressful)

Personal Stress Level (1-10): (no stress) 1 2 3 4 5 6 7 8 9 10 (very stressful)

Recreational Activities/Hobbies: _____

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

Circle any of the following symptoms you currently have or that you have experienced in the past:

MUSCULOSKELETAL
- Neck pain/stiffness
- Shoulder pain/stiffness
- Arm pain/tingling/numbness
- Hand pain/tingling/numbness
- Mid back pain/stiffness
- Low back pain/stiffness
- Hip pain
- Knee pain
- Pain/tingling down leg
- Foot/ankle pain
- Jaw pain/clicking

NERVOUS SYSTEM
- Headaches
- Dizziness
- Fainting
- Convulsions

GASTROINTESTINAL
- Decreased/Increased appetite
- Excessive thirst
- Frequent nausea
- Vomiting
- Diarrhea
- Constipation
- Excessive gas
- Hemorrhoids
- Liver problems
- Gallbladder problems
- Abdominal pain/cramps
- Heartburn

GENERAL
- Weight problems
- Allergies
- Fever

EARS, EYES, NOSE, THROAT
- Hearing loss
- Ringing in ears
- Ear aches/pressure
- Vision problems
- Dental problems
- Sore throat
- Stuff nose
- Loss of smell
- Sinus pressure
- Sinus infections

HEART AND LUNGS
- Chest pain
- Shortness of breath
- Blood pressure problems
- Heart problems
- Stroke
- High Cholesterol
- Murmur
- Palpitations
- Lung problems/congestion
- Cough
- Wheezing
- Varicose veins
- Swollen extremities
- Blue extremities

ENDOCRINE
- Heat/cold intolerance
- Goiter

PSYCHOLOGIC
- Anxiety
- Depression
- Phobias
- Mood Swings

GENITOURINARY
- Bladder infections
- Painful urination
- Frequent urination
- Prostate problems

MALE
- Prostate problems
- Impotence

FEMALE
- Menstrual irregularity
- Menstrual cramps
- Vaginal pain/bleeding
- Yeast infections
- History of breast cancer
- Breast pain/lumps
- Infertility/trouble conceiving
- Currently Pregnant

FAMILY HISTORY: Please include cancer, heart disease, stroke, diabetes, osteoporosis, scoliosis, etc.

Member	Age/Living?	Major illness or chronic conditions
Mother		
Father		
Siblings		

Is there anything else you would like us to know?

_____

_____

ASSIGNMENT OF BENEFITS: I give permission for Ridgeview Chiropractic to bill my insurance company for charges rendered today and for future visits. I understand that I am responsible for any fees not covered by insurance. I give permission to Ridgeview Chiropractic to send health records to my insurance company, if requested, to receive payment from my insurance.

Patient's Signature _____

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____