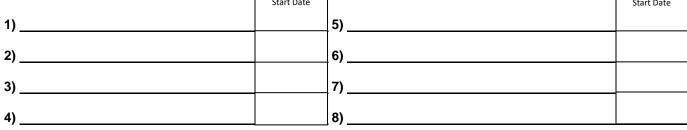
## Patient Health History

Today's Date / / Signatur	re of Patient
Patient Title: (check one)	□ Miss □ Dr. □ Prof. □ Rev.
First Name	_ Nick Name
Last Name	_ Middle Name Suffix
Address 1	
	_ StateZip Code
	Secondary Phone
Mobile Phone	
Home email	
Which email address would you like us to use to communicate with you? (check one)	
Contact Method (check one)	
□ Primary Phone □ Secondary Phone □ Mobile Phone □ Home Email □ Work Email	
Date of Birth / / Age	Gender (check one) I Male I Female I Unspecified
Marital Status (check one) Single Married Other	
SSN	
Employment Status (check one)	
□ Employed □ FT Student □ PT Student	Other  Retired  Self Employed
Current medications, including frequency and dosage if known. If there are no current medications, check here: □	
· · · · · · · · · · · · · · · · · · ·	]
Start Date	Start Date



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 INO 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: \_\_\_\_\_/\_\_\_\_