Lentini Chiropractic

Patient Health History

Please fill out this entire form to the best of your ability. All information obtained in this history document helps us to meet health care requirements and can be extremely helpful to assist you in realizing your optimal health and wellness goals.

Today's Date: _____/_____/_____

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

First Name _____ **Nick Name** _____ **Last Name** _____

Email _____ **May we send billing information to this email?** ❑Yes ❑No

Primary Phone # _____ **Secondary Phone #** _____ **Mobile #** _____

Contact Method *(check one)* ❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Email

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other

Social Security #: _____

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 ❑Yes ❑No ❑Unknown **Ethnicity** ❑ Hispanic/Latino ❑ Not Hispanic/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, then write the answer to that question below)*

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

Verification Answer to the Chosen Question: _____

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

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current occasional 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) Brand Name_____ Dosage_____ Frequency / Quantity _____ Start Date _____
2) Brand Name_____ Dosage_____ Frequency / Quantity _____ Start Date _____
3) Brand Name_____ Dosage_____ Frequency / Quantity _____ Start Date _____
4) Brand Name_____ Dosage_____ Frequency / Quantity _____ Start Date _____
5) Brand Name_____ Dosage_____ Frequency / Quantity _____ Start Date _____

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

1) Allergy _____ Reaction Description _____
2) Allergy _____ Reaction Description _____
3) Allergy _____ Reaction Description _____

List any relevant family health history. **If none, check here:** ❑

1) Relation _____ Condition _____
2) Relation _____ Condition _____
3) Relation _____ Condition _____

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

Have you had any surgeries? ❑ Yes ❑ No **If yes, when?** _____
Describe: _____

Have you had any laboratory test performed in the last 6 months? ❑ Yes ❑ No

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

Occupational History:

Job Description _____ **Schedule** ❑ part-time ❑ full-time

Activities _____ **Physical stress level** ❑ Low ❑ Medium ❑ High

Social History: (cups/day, hours/night, days/week)

Alcohol Consumption _____ **Coffee Consumption** _____
Soda Pop Consumption _____ **Water Consumption** _____
Sleep Amount _____ **Exercise Frequency** _____

Please rank:	**poor**			**not well**				**good**			**excellent**
1) How well you eat	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10

Please rank:	**no stress**				**some**			**much**			**extreme**
2) Physical Stress Level	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
3) Emotional Stress Level	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10

Thank you for completing this form.

This section to be completed by clinic staff:

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