

# NEW YEAR HEALTH HISTORY UPDATE

## Information about You

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex ( )F ( )M SSN: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_  
Employer's Name \_\_\_\_\_ Employer's Address \_\_\_\_\_

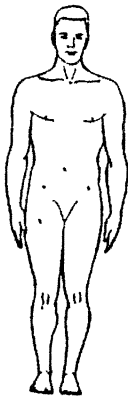
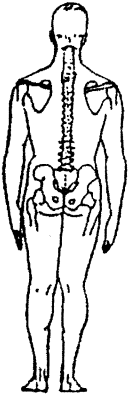
## Information about Your Health

What are your most pressing health concerns? \_\_\_\_\_  
\_\_\_\_\_

For how long? \_\_\_\_\_

Are your health concerns... ( )improving ( )getting worse ( )staying the same

Where is the problem? Please use the illustrations and lines below to explain.



Front \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Back \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your pain... ( )burning ( )dull ( )sharp ( )shooting ( )aching ( )throbbing

When do you feel your pain... ( )constantly ( )frequently ( )intermittently ( )occasionally

Are your symptoms affected by... ( )standing ( )sitting ( )bending ( )walking ( )lying down ( )weather

Do your symptoms interfere with... ( )work ( )day-to-day activities ( )sleep ( )play ( )\_\_\_\_\_

On a scale of 1-10 (1=least, 10=most), please rate the severity of your symptoms

1    2    3    4    5    6    7    8    9    10

## Information about Your Financial Responsibilities

Who is responsible for payment? \_\_\_\_\_

How will you pay for your care? ( ) cash ( ) check ( ) credit card # \_\_\_\_\_ Exp. \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group policy # \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Insured's Name \_\_\_\_\_ Subscriber ID# \_\_\_\_\_

Insured's DOB: \_\_\_\_\_ Insured's SSN: \_\_\_\_\_

The above is accurate to the best of my knowledge.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date