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? ______________________

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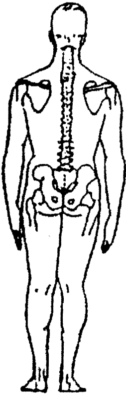
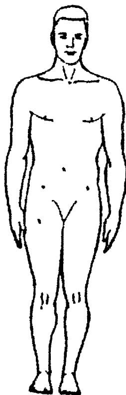
For how long? ______________________

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

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





Front ______________________

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Back ______________________

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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