



Health History

Name: _____

Medical History

<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Cancer / Tumors	<input type="checkbox"/> Headache	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Alcohol Use	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Herniated / Slipped Disc	<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Constipation / Diarrhea	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> Allergies / Hay Fever	<input type="checkbox"/> Cough	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Jaw Pain / Clicking	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Urinary Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fracture	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Weight gain / loss
<input type="checkbox"/> Bowel / Bladder Problems	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Skin rash / lesions	Other: _____
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Stroke	

● Please list ALL Surgeries and Hospitalizations: _____

● Please list ALL Medications currently taking: _____

● List any medication Allergies and Sensitivities: _____

● Previous Injuries: Motor Vehicle Work Other _____

● Female Patients ONLY: Are you Pregnant: Yes No Unsure Date of last menstrual period: _____

Job Description / Responsibilities

Job Requirements	Never	Occasional (0 - 1/3 day)	Frequent (1/3 - 2/3 day)	Constant (2/3 - full day)	Provide a brief job description
Lifting 1-10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lifting 11-20 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lifting 21-50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lifting 51-99 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lifting >100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneeling/Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bending/Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Health Insurance Portability and Accountability Act (HIPAA)

We understand that medical information about you and your health is personal and we are committed to protect this information. Each day we create a record of the care and services you receive at our facility. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of the records of your care generated at our facility.

A HIPAA policy describes how health information about you may be used and disclosed and how you can get access to this information.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a copy of our Privacy Notice.

A copy of our Privacy Notice will be provided to you upon request. By signing below you acknowledge you have either obtained a copy of our Privacy Notice, received satisfactory clarification of particular conditions, or choose to obtain a copy at a later date.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Office or office manager.

BY SIGNING BELOW I ACKNOWLEDGE THAT THE INFORMATION PROVIDED ABOVE IS BOTH ACCURATE AND COMPLETE.

Signature of Patient / Legal Guardian and Relationship to Patient

Date

Printer Name of Patient / Legal Guardian