HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____ /_____/_____

WELCOME: We welcome you and want you to provide you with the best possible care. We will conduct a thorough history and evaluation to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this form, please ask for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

PERSONAL INFORMATION:

Name: (*First*) _____ (*Middle*) _____ (*Last*) _____ Jr., II, III, IV

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ /_____/_____ Age: ____ Marital Status (*Circle*): Divorced Married Single Separated Widowed

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Email Address: _____@_____

Spouses Name: _____ Is your spouse a patient in our office? □ **Yes** □ **No**

Names & Ages of Children: _____

Employer /Employment Status □Employed □Unemployed □Full Time / □Part Time Student □Other

Business Name: _____ Occupation/Job Title: _____

Business Address: _____

Business Phone: (_____) _____-_____ Type of Work: _____

Is it ok to contact you at work? □ Yes □ No

Emergency Contact Information

Name: (*First*) _____ (*Middle*) _____ (*Last*) _____ Jr., II, III, IV

Address: _____ City: _____ State: _____ Zip: _____

Relationship: _____ Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

PAYMENT/INSURANCE INFORMATION:

Is the condition(s) that brought you here today due to an automobile accident or on the job injury? □ Yes □ No

Personal Health Insurance Carrier: _____ Health ID card #: _____

Insured Person's Name: _____ Group #: _____

Insured Person's Date of Birth: _____ /_____/__ ___

PAIN DIAGRAM

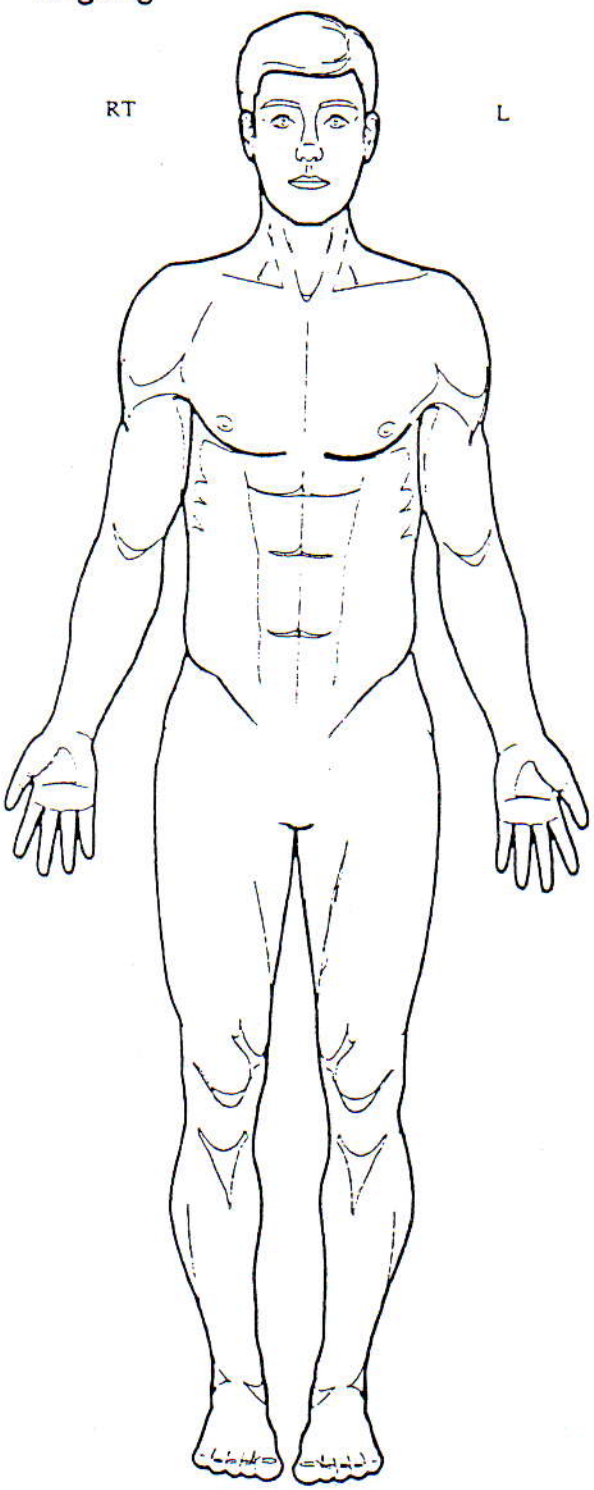
Patient Name:_____ **Date:**_____

Please complete the following Pain Diagram by using the letters at the left to indicate on the diagram your areas of pain:

P = Pain
B = Burning
N = Numbness
S = Stiffness
T = Tingling

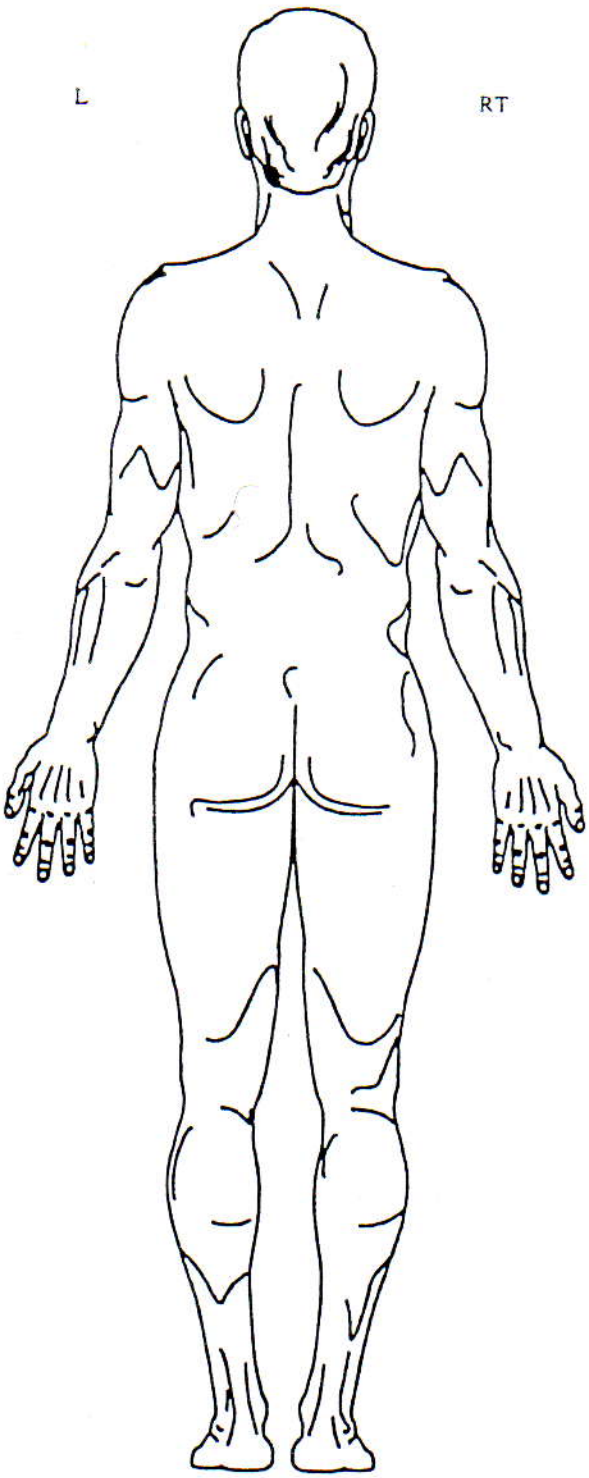
FRONT

RT L



BACK

L RT



PRIMARY SYMPTOM _____
When did it start? _____
Describe the condition: _____
What do you think caused the problem? _____
Rate the pain from 1-10: At it's worst __ __ At the present time ___ At least severe ___
Does the pain travel? □ Yes □ No If yes, from where to where? _____
Is condition getting worse? □ Yes □ No
List the activities that this condition prevents you from doing? _____
List past treatment for this condition and if it helped _____
_____

SECONDARY SYMPTOM _____
When did it start? _____
Describe the condition: _____
What do you think caused the problem? _____
Rate the pain from 1-10: At it's worst ____ At the present time ___ At least severe ___
Does the pain travel? □ Yes □ No If yes, from where to where? _____
Is condition getting worse? □ Yes □ No
List the activities that this condition prevents you from doing? _____
_____
List past treatment for this condition and if it helped _____
_____

ADDITIONAL SYMPTOM _____
When did it start? _____
Describe the condition: _____
What do you think caused the problem? _____
Rate the pain from 1-10: At it's worst ____ At the present time ___ At least severe ___
Does the pain travel? □ Yes □ No If yes, from where to where? _____
Is condition getting worse? □ Yes □ No
List the activities that this condition prevents you from doing? _____
_____
List past treatment for this condition and if it helped _____
_____

LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:
_____
_____
_____
_____

LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:
_____
_____
_____
_____

LIST FAMILY HISTORY OF DISEASE: MOTHER, FATHER, SIBLINGS, GRANDPARENTS:
_____
_____
_____
_____

EXERCISE Yes or No TOBACCO Yes or No ALCOHOL Yes or No STRESS Low Medium High

REVIEW OF SYSTEMS

Patient Name: _____ Today's Date: _____ /_____/_____

INSTRUCTIONS: Please fill out all the sections. If none of the conditions apply, select "None."

Constitutional:
- **None**
- Chills
- Daytime Drowsiness
- Fatigue
- Fever
- Night Sweats
- Weight Gain
- Weight Loss

Eyes/Vision:
- **None**
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Eye Pain
- Field Cuts
- Glaucoma
- Itching *(around the eyes)*
- Photophobia
- Tearing
- Wears Glasses or Contacts

Ears, Nose and Throat:
- **None**
- Bleeding
- Dental Implants
- Dentures
- Difficulty Swallowing
- Discharge
- Dizziness
- Ear Drainage
- Ear Infection*(s)*
- Ear Pain
- Fainting
- Headaches
- Head Injury *(history of)*
- Hearing Loss
- Hoarseness
- Loss of Smell
- Nasal Congestion
- Nose Bleeds
- Postnasal Drip
- Rhinorrhea *(runny nose)*
- Sinus Infections
- Snoring
- Sore Throats
- Tinnitus *(ringing in the ears)*
- TMJ Disorder

Cardiovascular:
- **None**
- Angina *(chest pain or discomfort)*
- Chest Pain
- Claudication *(leg pain or achiness)*
- Heart Murmur
- Heart Problems
- Orthopnea *(difficulty breathing while lying)*
- Palpitations *(irregular or forceful heartbeat)*
- Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
- Shortness of Breath
- Swelling of Leg*(s)*
- Ulcers
- Varicose Veins

Gastrointestinal:
- **None**
- Abdominal Pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice *(yellowing of the skin)*
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber *(quality)*
- Abnormal Stool Color
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood

Respiration:
- **None**
- Asthma
- Coughing up blood
- Shortness of Breath
- Sputum Production
- Wheezing

Endocrine:
- **None**
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Frequent Urination
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

Skin:
- **None**
- Changes in Nail Texture
- Changes in Skin Color
- Hair Growth
- Hair Loss
- Hives
- Itching
- Paresthesia (numbness, prickling, or tingling)
- Rash
- History of Skin Disorders
- Skin Lesions or Ulcers
- Varicosities

Nervous System:
- **None**
- Dizziness
- Facial Weakness
- Headaches
- Limb Weakness
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors
- Unsteadiness of Gait

Allergy:
- **None**
- Anaphylaxis *(history of)*
- Food Intolerance
- Itching
- Nasal Congestion
- Sneezing

Hematology:
- **None**
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusion*(s)*
- Bruises easily
- Fatigue
- Lymph Node Swelling

Psychological:
- **None**
- Anhedonia *(inability to experience joy or enjoy life)*
- Anxiety
- Appetite Changes
- Behavioral Change*(s)*
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Insomnia
- Memory Loss
- Mood Change*(s)*

Female:
- **None**
- Birth Control Therapy
- Breast Lumps / Pain
- Burning Urination
- Cramps
- Frequent Urination
- Hormone Therapy
- Irregular Menstruation
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

Male:
- **None**
- Burning Urination
- Erectile Dysfunction
- Frequent Urination
- Hesitancy or Dribbling
- Prostate Problems
- Urine Retention

Patient Signature: _____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above-named patient: _____ _____

Wellness First 14360 Sommerville Court Midlothian VA 23113 Doctor Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process my insurance claims.

AUTHORIZATION OF ASSIGNMENT:

I authorize payment of medical benefits to Wellness First Inc. for services rendered to me.

REIMBURSEMENT POLICY:

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company, and all services rendered to you are ultimately your responsibility.

ACCEPTANCE AS A PATIENT:

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins or terminate my care as a patient if during treatment, I am not following the treatment plan for my condition or to be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of an evaluation are not considered treatment but are part of a process of information gathering so that the doctor can determine whether to accept me as a patient.

_____

PATIENT PRINTED NAME

_____

PATIENT SIGNATURE

_____

DATE

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