

# Personal History

**Current Date** \_\_\_\_\_ **Email** \_\_\_\_\_ **SSN** \_\_\_\_\_  
**Name** \_\_\_\_\_ **Home Phone** \_\_\_\_\_ **Bus Phone** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Birthdate** \_\_\_\_\_ **Sex**  **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_  
**Employer** \_\_\_\_\_ **Type Work** \_\_\_\_\_  
 **Married**    **Seperated**    **Widowed**    **Divorced**   **Age of Children** \_\_\_\_\_  
**Name/Spouse** \_\_\_\_\_ **Spouse Employer** \_\_\_\_\_  
**In Case of Emergency Contact:**  
**Contact Name** \_\_\_\_\_ **Contact Phone** \_\_\_\_\_  
**Referred by** \_\_\_\_\_  
**Who is Responsible for your Bill?**  
 **Self**    **Insurance**    **Employer**    **Spouse**    **Other** \_\_\_\_\_

## Past Health History

Please check applicable items

### OPERATIONS

- Appendectomy**    **Rectal**    **Tonsillectomy**    **Gall Bladder**    **Hernia**    **Female Organs**  
 **Other** \_\_\_\_\_

### VACCINATIONS & INJECTIONS

- Diphtheria**    **Polio**    **Small Pox**    **Tetenus**    **Typhoid**    **Spinal Tap or Injection**

### ACCIDENTS OR FALLS (Please describe)

\_\_\_\_\_

### FRACTIONS OR DISLOCATIONS

\_\_\_\_\_

### HABITS

- Alcohol**    **Coffee**    **Exercise**    **Hobbies**    **Tea**    **Tobacco**   **Sleep (No Hours)** \_\_\_\_\_

**Are you taking any drugs?** (please name) \_\_\_\_\_

**Have you ever had a nervous breakdown?** \_\_\_\_\_

**Have you or any member of your family been treated for a mental disorder?** \_\_\_\_\_