Health History

Texas Injury Clinic

Name:

Medical History				
❑ Abdominal Pain	❑ Cancer / Tumors	❑ Headache	❑ Parkinson's Disease	❑ Suicide Attempt
❑ Alcohol Use	❑ Chest Pain	❑ Herniated / Slipped Disc	❑ Pinched Nerve	❑ Thyroid Problems
❑ AIDS/HIV	❑ Constipation / Diarrhea	❑ High Blood Pressure	❑ Pneumonia	❑ Tobacco Use
❑ Allergies / Hay Fever	❑ Cough	❑ High Cholesterol	❑ Prostate Problems	❑ Tuberculosis
❑ Anemia	❑ Depression	❑ Jaw Pain / Clicking	❑ Psychiatric Care	❑ Ulcers
❑ Arthritis	❑ Fibromyalgia	❑ Kidney Disease	❑ Seizure Disorder	❑ Urinary Problems
❑ Asthma	❑ Fracture	❑ Liver Disease	❑ Shortness of Breath	❑ Weight gain / loss
❑ Bowel / Bladder Problems	❑ Heart Disease	❑ Osteoporosis	❑ Skin rash / lesions	Other:
❑ Bronchitis	❑ Hepatitis	❑ Pacemaker	❑ 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	❑	❑	❑	❑	
Lifting 11-20 pounds	❑	❑	❑	❑	
Lifting 21-50 pounds	❑	❑	❑	❑	
Lifting 51-99 pounds	❑	❑	❑	❑	
Lifting >100 pounds	❑	❑	❑	❑	
Sitting	❑	❑	❑	❑	
Standing	❑	❑	❑	❑	
Kneeling/Squatting	❑	❑	❑	❑	
Bending/Stooping	❑	❑	❑	❑	
Pushing/Pulling	❑	❑	❑	❑	
Twisting	❑	❑	❑	❑	
Reaching	❑	❑	❑	❑	

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