NW HEALTH SOLUTIONS
520-498-0082(phone) 520-498-0085(fax)

HEALTH HISTORY FORM

PATIENT NAME: _____ Date_____

Understanding your health history is important to us. Please take the time and effort to fully and accurately provide us with the following information:

Current family care provider:

Name	Address	Phone	Timeframe

Past family care provider(s):

Name	Address	Phone	Timeframe

Other medical providers seen in past 5 years pre-dating the collision:

	Name	Address	Phone	Timeframe	Reason
1.					
2.					
3.					
4.					
5.					

Other medical providers seen at any time in your life prior to the collision for conditions similar to those for which you currently seek treatment:

	Name	Address	Phone	Timeframe	Reason
1.					
2.					
3.					
4.					
5.					

Prior automobile accidents with injury:

	Date	Location	Timeframe	Areas of injury
1.				
2.				
3.				
4.				
5.				

Prior work related injuries:

	Date	Location	Timeframe	Areas of injury
1.				
2.				
3.				
4.				
5.				

Prior slip/fall injuries:

	Date	Location	Timeframe	Areas of injury
1.				
2.				
3.				
4.				
5.				

Other injuries of relevance:

	Date	Location	Timeframe	Areas of injury
1.				
2.				
3.				