

**Patient Health History**

(Please use blue or black ink only)

Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Sex: **M** **F** Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Handedness: **R** **L**

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

What problem brought you to our office today?

\_\_\_\_\_  
\_\_\_\_\_

How long have you had this problem?

\_\_\_\_\_

How often does it occur?

\_\_\_\_\_

Is your problem related to work or an auto accident? If so, when?

\_\_\_\_\_

Can you describe your symptoms? (aching, etc.)

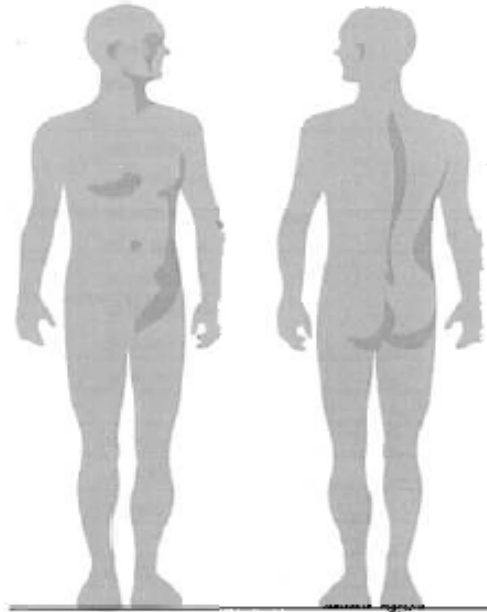
\_\_\_\_\_  
\_\_\_\_\_

What makes your symptoms worse?

\_\_\_\_\_

What makes your symptoms better?

\_\_\_\_\_



**Circle the area above that is painful**  
**Shade areas of numbness or tingling**

Circle the number that best describes your pain.

no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain N/A

What treatments have you already attempted?

	Effective	Somewhat	Not Effective	Worse	When?
Physical Therapy					
Chiropractic Care					
Pain Clinic					
Rehab Physician					
Medications					
Heat/Ice					
Traction					
Rest					

**Office Use Only:**

Temperature: \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Weight: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**Diagnostic Studies:** What tests have been completed? (list dates)

MRI \_\_\_\_\_ CT Scan \_\_\_\_\_ X-rays \_\_\_\_\_ EMG \_\_\_\_\_

**Past Medical History:** Please mark any medical problem that you **have now** or **have had in the past**.

High blood pressure     Diabetes     Emphysema/COPD     Asthma     TB  
 Stroke     TIA     Heart Disease     Angina     Kidney Dis.  
 High Cholesterol     Aneurysm     Stomach Ulcer     Hepatitis     Acid Reflux  
 Thyroid disease     Osteoporosis     Seizure disorder     Rheumatoid     Fibromyalgia  
 Currently pregnant     Depression     Bleeding disorder  
Other psychiatric illness (type): \_\_\_\_\_  
Cancer (type): \_\_\_\_\_  
Other medical illness (describe:): \_\_\_\_\_

**Past Surgical History:** Please list any **surgery** you have had in the past with the approximate date.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Medications:** List the medications and dose that you take.

Name	Dosage	How Often	Name	Dosage	How Often
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Medication Allergies:** List any medication allergy you have experienced.

Name	Reaction	Name	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

**Social History:**

What is your current marital status?  Single  Married  Divorced  Widowed

What is your current occupation? \_\_\_\_\_

What is your current work status?  Fulltime  Part Time  Limited Duty  Unable to Work  Without Employment

The last date I worked was: \_\_\_\_\_ I have been on disability since: \_\_\_\_\_

Do you smoke tobacco? **YES** **NO** How many packs/day? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you consume alcohol? **YES** **NO** How much? \_\_\_\_\_ How often? \_\_\_\_\_

Have you ever had a problem with alcohol in the past? **YES** **NO** When? \_\_\_\_\_

Have you ever used illegal drugs? **YES** **NO** When? \_\_\_\_\_

Have you ever had an addiction problem with narcotic pain medications? **YES** **NO** When? \_\_\_\_\_

**Family History:** Please mark any medical problems that exist in your family.

\_\_\_ High blood pressure    \_\_\_ Diabetes    \_\_\_ Heart Disease    \_\_\_ Emphysema/COPD  
\_\_\_ Stroke    \_\_\_ Bleeding Disorder    \_\_\_ Reaction to anesthesia  
\_\_\_ Cancer (type:)  
\_\_\_ Other medical illness (describe:)

**Review of Systems for the last six months:** Circle "yes" or "no" for each sign/symptom.

<u>CONSTITUTIONAL:</u> Yes / No Weight Gain Yes / No Weight Loss Yes / No Fever Yes / No Chills Yes / No Sexual Dysfunction	<u>GASTROINTESTINAL:</u> Yes / No Abdominal Pain Yes / No Diarrhea Yes / No Constipation Yes / No Bowel Incontinence Yes / No Blood in Stool	<u>MUSCULOSKELETAL:</u> Yes / No Leg Cramps Yes / No Swelling Yes / No Painful Joints Yes / No Muscle Loss Yes / No Bruising
<u>EYES:</u> Yes / No Blurred Vision Yes / No Double Vision Yes / No Loss of Vision	<u>URINARY:</u> Yes / No Difficulty Urinating Yes / No Urinary Incontinence Yes / No Urgency	<u>SKIN:</u> Yes / No Cancer Yes / No Rash Yes / No Ulcer
<u>HEAD/EARS/NOSE/THROAT:</u> Yes / No Headache Yes / No Nasal Drainage Yes / No Hearing Loss	<u>NEUROLOGICAL:</u> Yes / No Seizure Yes / No Memory Loss Yes / No Confusion	<u>ALLERGY:</u> Yes / No Seasonal Yes / No Tape Yes / No Food
<u>CARDIOVASCULAR/RESPIRATORY:</u> Yes / No Chest Pain (angina) Yes / No Palpitations Yes / No Heart Arrhythmia Yes / No Shortness of Breath	<u>PSYCHIATRIC:</u> Yes / No Depression Yes / No Mania Yes / No Other	Yes / No Other: _____

For "yes" responses, which physician(s) is/are treating these conditions? \_\_\_\_\_

**I hereby certify that the above information is correct to the best of my knowledge. I will not hold my physician or any of his staff responsible for any errors or omissions I have made in completing this form.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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Office Use Only:

**Reviewed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_