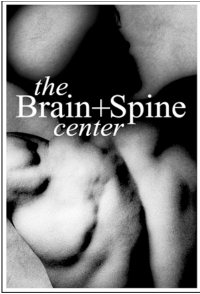


Patient Health History

(**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.)

____

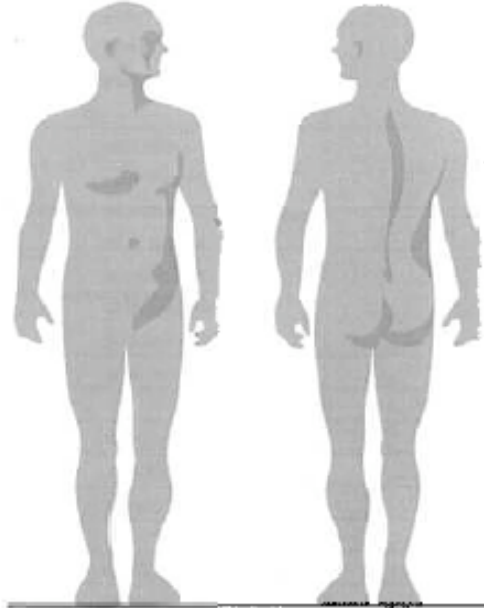
____

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 NECK or BACK pain.

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

Circle the number that best describes your SHOULDER/ARM/HAND or BUTTOCK/LEG/FOOT 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:________________

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.

CONSTITUTIONAL:
Yes / No Weight Gain
Yes / No Weight Loss
Yes / No Fever
Yes / No Chills
Yes / No Sexual Dysfunction

EYES:
Yes / No Blurred Vision
Yes / No Double Vision
Yes / No Loss of Vision

HEAD/EARS/NOSE/THROAT:
Yes / No Headache
Yes / No Nasal Drainage
Yes / No Hearing Loss

CARDIOVASCULAR/RESPIRATORY:
Yes / No Chest Pain (angina)
Yes / No Palpitations
Yes / No Heart Arrhythmia
Yes / No Shortness of Breath

GASTROINTESTINAL:
Yes / No Abdominal Pain
Yes / No Diarrhea
Yes / No Constipation
Yes / No Bowel Incontinence
Yes / No Blood in Stool

URINARY:
Yes / No Difficulty Urinating
Yes / No Urinary Incontinence
Yes / No Urgency

NEUROLOGICAL:
Yes / No Seizure
Yes / No Memory Loss
Yes / No Confusion

PSYCHIATRIC:
Yes / No Depression
Yes / No Mania
Yes / No Other

MUSCULOSKELETAL:
Yes / No Leg Cramps
Yes / No Swelling
Yes / No Painful Joints
Yes / No Muscle Loss
Yes / No Bruising

SKIN:
Yes / No Cancer
Yes / No Rash
Yes / No Ulcer

ALLERGY:
Yes / No Seasonal
Yes / No Tape
Yes / No Food
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:**____________

Office Use Only:

Reviewed by: ________________________________ **Date:** ____________