

Patient History

Patient Name _____ Date _____

Reason For Visit _____

When did your symptoms appear? _____

How do you believe your problem began? _____

Is it due to an injury which occurred at :

___ Home ___ Work ___ Automobile Accident ___ Other _____

If so, what was the date of the injury and to whom did you report it? _____

Please describe the incident _____

Attorney's Name (if applicable) _____

Is this condition getting progressively worse? Yes No Unknown

Type of Pain: Sharp Dull Throbbing Numbness Aching
 Shooting Burning Tingling Cramps Stiffness
 Swelling Other

How often do you have this pain? _____

Is it consistent or does it come and go? _____

Does your pain ever wake you from sound sleep? Yes No

Does it interfere with you Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform include : Sitting Standing
 Walking Bending Lying down

What treatment have you already received for your condition? Physical Therapy
 Medical Chiropractic None Other

Name and address of other doctor(s) who have treated you for your condition

Have you previously injured or had similar symptoms to this body part before? _____

In the past have you ever been in any accidents; auto, fall down stairs, fall from ladder, etc? _____

Have you recently had any x-rays, CT, or MRI? If so, when and where? _____

Name _____ Date _____

Below are listed common symptoms which may suggest the presence of an ailment involving a particular body system. If you have ever had a listed symptom in the **past**, please check that symptom in the **left hand column**. If you are **presently** troubled by a particular symptom, check that symptom in the **right hand column**.

Past	MUSCULOSKELETAL	Present
<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>
<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>
<input type="checkbox"/>	Pain in Upper Arm or Elbow	<input type="checkbox"/>
<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>
<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>
<input type="checkbox"/>	Lower Back Pain	<input type="checkbox"/>
<input type="checkbox"/>	Pain in Upper Leg or Hip	<input type="checkbox"/>
<input type="checkbox"/>	Pain in Ankle or Foot	<input type="checkbox"/>
<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>
<input type="checkbox"/>	Swelling of Joints	<input type="checkbox"/>
<input type="checkbox"/>	Stiffness of Joints	<input type="checkbox"/>

Past	NERVOUS SYSTEM	Present
<input type="checkbox"/>	Depression	<input type="checkbox"/>
<input type="checkbox"/>	Insomnia (trouble sleeping)	<input type="checkbox"/>
<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>
<input type="checkbox"/>	Fainting	<input type="checkbox"/>
<input type="checkbox"/>	Convulsions	<input type="checkbox"/>
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>
<input type="checkbox"/>	Headache	<input type="checkbox"/>
<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>
<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>
<input type="checkbox"/>	Tinnitus (ear noises)	<input type="checkbox"/>
<input type="checkbox"/>	Ear Pain	<input type="checkbox"/>
<input type="checkbox"/>	Impaired Vision	<input type="checkbox"/>
<input type="checkbox"/>	Eye Pain	<input type="checkbox"/>

Past	CARDIOVASCULAR	Present
<input type="checkbox"/>	Rapid Heart Beat	<input type="checkbox"/>
<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>

Past	ENDOCRINE	Present
<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>
<input type="checkbox"/>	Abnormal Weight Gain	<input type="checkbox"/>
<input type="checkbox"/>	Abnormal Weight Loss	<input type="checkbox"/>

Past	RESPIRATORY	Present
<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>
<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>
<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>
<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>

Past	GYNECOLOGIC	Present
<input type="checkbox"/>	Pain during Menstruation	<input type="checkbox"/>
<input type="checkbox"/>	Irregular Menstrual Flow	<input type="checkbox"/>
<input type="checkbox"/>	Spotting	<input type="checkbox"/>
<input type="checkbox"/>	Menopausal Symptoms	<input type="checkbox"/>

Past	GENITO-URINARY	Present
<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>
<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>
<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>
<input type="checkbox"/>	Urethral Discharge	<input type="checkbox"/>

Past	GI TRACT	Present
<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>
<input type="checkbox"/>	Difficulty in Swallowing	<input type="checkbox"/>
<input type="checkbox"/>	Heartburn/Indigestion	<input type="checkbox"/>
<input type="checkbox"/>	Constipation	<input type="checkbox"/>

Past	SKIN	Present
<input type="checkbox"/>	Rash	<input type="checkbox"/>
<input type="checkbox"/>	Dermatitis or Eczema	<input type="checkbox"/>
<input type="checkbox"/>	Persistent Itching	<input type="checkbox"/>

Please check any of the following that apply to you :

Past		Present
<input type="checkbox"/>	Tobacco	<input type="checkbox"/>
<input type="checkbox"/>	Alcohol	<input type="checkbox"/>
<input type="checkbox"/>	Tranquilizers/Sedatives	<input type="checkbox"/>
<input type="checkbox"/>	Laxatives	<input type="checkbox"/>
<input type="checkbox"/>	Other _____	<input type="checkbox"/>
<input type="checkbox"/>	Coffee, cups per day _____	<input type="checkbox"/>

Past	CONDITION	Present
<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>
<input type="checkbox"/>	Rheumatic Heart Disease	<input type="checkbox"/>
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
<input type="checkbox"/>	Angina	<input type="checkbox"/>
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>
<input type="checkbox"/>	Stroke	<input type="checkbox"/>
<input type="checkbox"/>	Asthma	<input type="checkbox"/>
<input type="checkbox"/>	Cancer	<input type="checkbox"/>
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
<input type="checkbox"/>	Drug or Alcohol Dependency	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
<input type="checkbox"/>	Ulcer	<input type="checkbox"/>
<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>
<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>

Past

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[]

[]

OTHER

Present

[]

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Primary Care Physician _____	Date Last Seen _____
Address _____	
Phone _____	

HEALTH HISTORY

Have you had any of the following: AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No Depression/ Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No Gout <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Measles <input type="checkbox"/> Yes <input type="checkbox"/> No Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No Polio <input type="checkbox"/> Yes <input type="checkbox"/> No Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
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Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Tumors, Growth <input type="checkbox"/> Yes <input type="checkbox"/> No Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No Urinary Tract Infections <input type="checkbox"/> Yes <input type="checkbox"/> No Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No Other _____ _____ _____	<p>EXERCISE</p> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<p>HABITS</p> <input type="checkbox"/> Smoking Packs/Day _____ <input type="checkbox"/> Alcohol Drinks/Week _____ <input type="checkbox"/> Coffee/Caffeine Drinks Cups/Day _____ <input type="checkbox"/> High Stress Level Reason _____
<p>WORK ACTIVITY</p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor		

Are You Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Due Date _____	Do You Take Birth Control Pills? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Injuries/Surgeries You Have Had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY
Have your immediate family members had any of the following:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Back Problems
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ulcer or Stomach Problems
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Stroke
<input type="checkbox"/> Seizures-Convulsions	<input type="checkbox"/> Arthritis-Rheumatism
<input type="checkbox"/> HIV-Positive	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Asthma	<input type="checkbox"/> Headaches
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Circulation Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Osteoporosis