



HEALTH HISTORY

Date ____/____/____ Name _____ Date of Birth ____/____/____

Family Physician _____ Last visit ____/____/____ Referring Physician _____

CHIEF COMPLAINT: What is your chief problem or symptom? _____ Left Right (if applicable)

HISTORY OF PRESENT ILLNESS

What caused the problem or symptom to occur? (Be specific as possible) _____

When did the problem or symptom begin? _____ Date of Injury: ____/____/____

Was the pain: Sudden Gradual

Have you seen another doctor for this problem? No Yes If yes, who _____

What tests/procedures have been performed? X-rays CT Scan MRI EMG (nerve test) Other _____

Have you had this problem or symptom in the past? No Yes If yes, explain _____

Have you tried any of these treatments?

- Heat Ice Aspirin Tylenol Braces Advil or Aleve Muscle Relaxants Exercise Physical Therapy
- Chiropractic Cane/Walker Cortisone Shots Pain Meds

Can you describe your pain in any of the following ways?

- Burning Sharp Stabbing Dull Deep Ache Throbbing
- Constant Comes & Goes

How is your pain now, compared to when it started?

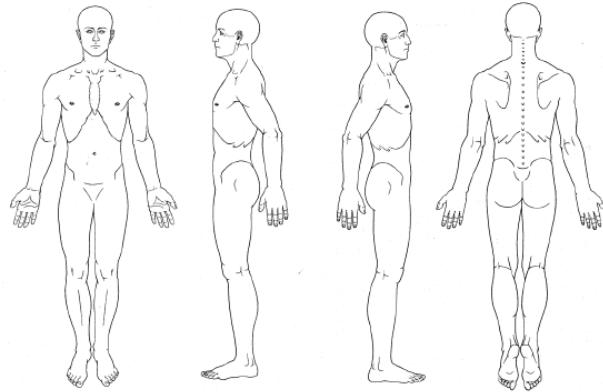
- Better Worse Same

Rate your current pain:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (most severe)

Do you have any of the following? No Yes

Numbness Weakness Tingling If yes, where?



Mark your area of pain with an X

Do any of the following make your pain worse?

- Walking Sitting Housecleaning Running Stairs Driving Sleeping Getting Dressed Sports

Other activity: _____

Have you had surgery for this problem? Yes No

Have you missed work for this problem? No Yes If yes, when _____

REVIEW OF SYSTEMS:

Circle all of the items that apply to you now and in the past:

- | | | | | |
|------------------|----------------------|----------------------|---------------------|----------------------|
| Arthritis / Gout | Depression / Anxiety | Pregnancy | Headaches | Heart Disease |
| Eye Pain/Strain | Dizziness | Blurred Vision | Thyroid Problems | Chest pain |
| Gall Stones | Chronic Cough | Jaw Pain | Chronic Fatigue | Neck Pain/Spasms |
| Weight Loss | Leg Cramps | Weakness | Seizures | Shoulder/Elbow Pain |
| Hypertension | Stroke | Kidney Stones | Shortness of Breath | Irregular Heart Beat |
| Abdominal Pain | Diabetes | Groin or Rectal Pain | Female Disorders | Urinary Problems |
| Broken Bones | Digestive Problems | Nausea/Vomiting | Irregular Bowels | Ringings in Ears |
| Mid-Back Pain | Wrist or Hand Pain | Low Back Pain | Hip/Knee/Leg Pain | Foot or Ankle Pain |

PAST HISTORY

List all previous surgeries (or none): _____

List current medications (or none): _____

List all drug allergies (or none): _____

FAMILY HISTORY

Has any member of your immediate family (parents or siblings) had this same problem? No Yes If yes, who _____

Father • Living Age and any Illnesses: _____ • Deceased -Cause of Death _____

Mother • Living Age and any Illnesses: _____ • Deceased -Cause of Death _____

Brother • Living Age and any Illnesses: _____ • Deceased -Cause of Death _____

Brother • Living Age and any Illnesses: _____ • Deceased -Cause of Death _____

Sister • Living Age and any Illnesses: _____ • Deceased -Cause of Death _____

Sister • Living Age and any Illnesses: _____ • Deceased -Cause of Death _____

SOCIAL HISTORY

Marital Status: Single Married Divorced Widow/Widower

Occupation: _____ If retired, where was your prior job? _____

Do you smoke? No Yes How much? _____ packs per day

Do you drink alcohol? No Daily Occasionally How many drinks? _____ per day / week

Where do you live? Apartment Own Home Are there stairs? Yes No

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Patient Signature _____ DOB: ____/____/____ Date ____/____/____

Dr. / Staff Initial _____