PATIENT HEALTH HISTORY

Name: _____ **Date**: _____

Are you CURRENTLY under the care of any of the following? (Please check ALL that apply)

☐ Medical Doctor
☐ Osteopath
☐ Acupuncturist
☐ Naturopath
☐ Chiropractor
☐ Massage Therapist
☐ Psychiatrist / Psychologist
☐ Other_____

Primary Care Physician: _____ **Referring Physician**: _____

Surgeries / Hospitalizations

Date	Type of surgery
_____	_____
_____	_____
_____	_____

Injuries (Fractures / dislocations / sprains)

Date	Type of injury
_____	_____
_____	_____
_____	_____

Do any of the following conditions apply to your past or current state of health?

☐ Coronary Heart Disease
☐ Congenital Heart Disease
☐ Dizziness / Fainting
☐ Congestive Heart Failure
☐ Peripheral Vascular Disease
☐ Irregular Heartbeat / Murmur
☐ Infectious Disease
☐ Heart Attack
☐ Stroke
☐ Hernia
☐ Cancer
☐ Allergies
☐ Pregnant
☐ Asthma
☐ Diabetes
☐ Angina
☐ Pacemaker
☐ Emphysema
☐ COPD
☐ Epilepsy
☐ Eating Disorder
☐ Bowel / Bladder Problems
☐ Recent Weight Loss / Gain
☐ High Blood Pressure
☐ Shortness of Breath
☐ Systematic Disease
☐ Osteoporosis
Other _____

Since the onset of your CURRENT symptoms, have you had any of the following?

Bowel / Bladder dysfunction	**Yes**	**No**	Fever / Chills	**Yes**	**No**
Numbness in genital or anal area	**Yes**	**No**	Numbness	**Yes**	**No**
Dizziness or fainting	**Yes**	**No**	Weakness	**Yes**	**No**
Unexplained weight change	**Yes**	**No**	Night pain / sweats	**Yes**	**No**

Do you smoke cigarettes or use chewing tobacco?	**Yes**	**No**
Do you drink alcohol?	**Yes**	**No**
Do you drink coffee or caffeinated beverages?	**Yes**	**No**
Are currently taking any medications? (Please list below)	**Yes**	**No**

Medication List:

_____

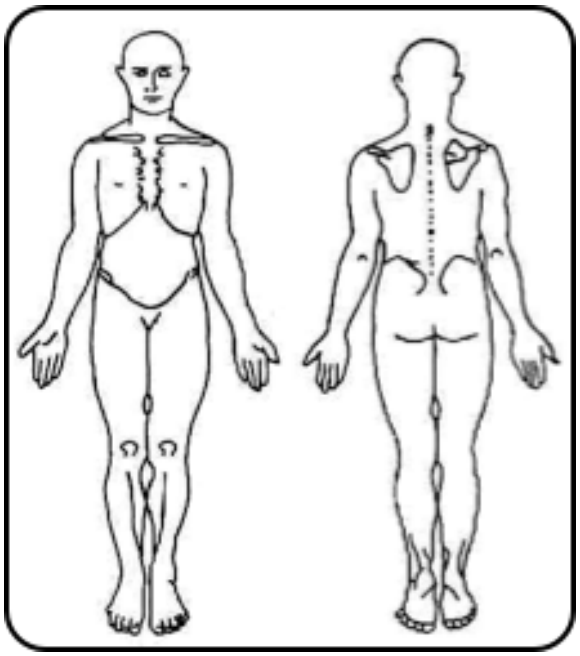
_____

Please fill out the pain diagram on the back of this form. Thank you

Please indicate on the diagram where your pain is located and briefly describe your current symptoms: _____

_____

_____



Briefly describe your current condition (i.e. – chief complaint that brought you here?) _____

_____

Date of this injury? _____

_____

Has your pain gotten **better, worse or** stayed the **same** since it began? _____

Please circle your **CURRENT** pain level, **WORST** pain level and **LEAST** pain level this last week:

No pain Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Describe your pain (sharp, dull, aching, tight, throbbing) _____

What makes your pain worse? (i.e. – lifting) _____

What makes your pain better? (i.e. – rest, movement) _____

How do you feel in the morning? (Please circle one) **Better** **Worse** **No Different**

How do you feel during the day? (Please circle one) **Better** **Worse** **No Different**

Has your sleep been interrupted by this pain? (Please circle one) **Yes** **No**

Have you had any of the following tests performed for this problem? ☐ X-ray ☐ MRI

☐ CT Scan ☐ Bone Scan ☐ Arthrogram ☐ Lab Tests ☐ Other: _____

(If work related) Employer: _____ Currently working: **Yes** **No**

Job Title: _____Work restrictions: _____

Regular lifting requirements: Lift lbs: _____ Push lbs: _____ Pull lbs: _____

What are your expectations / goals of treatment? _____