



Patient History Form

In order to provide you with the highest quality care, it is important for us to have a thorough health history. This information will remain a confidential part of your medical record. Please fill out the following information.

Patient Name: _____ **Primary Care MD:** _____ **Age:** ____ **Date:** _____

	Yes	No		Yes	No
Tuberculosis			Shortness of Breath		
Cancer			Fainting/Dizziness/Falls/Imbalance		
Ulcers			Pregnancy		
Low/High Blood Pressure			Hernia		
Bowel/Bladder Problems			Fracture		
Neck Injury			Alcoholism/ Chemical Dependency		
Back Injury			Blood Clots		
Arthritis/Joint Swelling			Kidney Disease		
Headaches/Migraines			Epilepsy/Seizures		
Hepatitis			Do you exercise regularly?		
Allergies/Asthma			Do you smoke?		
Heart Problems/ Pacemaker/Chest Pain			Are you in a relationship where you are being hit, kicked, slapped or otherwise hurt?		
Diabetes/Neuropathy			Hearing Loss/Ringing in ears?		
HIV/AIDS			Cataracts /Glaucoma /Macular Degeneration		
Stroke/Head/Brain Injury			Do you feel safe at home?		

If you checked yes to any of the above please comment:

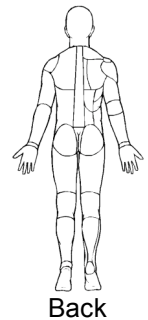
Please mark your area of discomfort or dysfunction on the body diagrams:

When did you first notice the pain/problem or have functional limitations due to this condition or injury?

First Episode: _____

Subsequent Episode: _____

Most Recent Episode: _____



How did your injury/symptoms occur? _____

If you have pain please complete the following pain scale: (0=No Pain: 10=The Worst Pain You Can Imagine):

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

What makes your symptoms better? _____ Worse? _____

Have you had any surgery for your injury/condition? _____ Date of surgery: _____

Have you received any injections for your injury/condition? _____ Have you had an MRI, X-ray or other tests? _____

Have you received physical therapy/occupational therapy or chiropractic care for your current condition? _____

Please list the medications you are currently taking on the back of this form or ask us to photocopy your list.