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:_______

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

Front

Back

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?__________

BOM 140 A