Patient History Form

Name: _____ Date: _____

Appointment date: _____

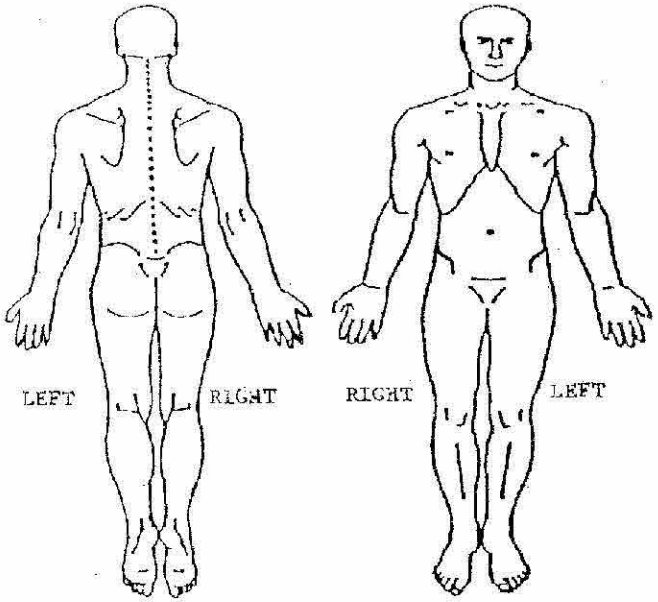
Current age: _____

SYMPTOM DIAGRAM

Current Pain Location – Indicate on drawing by circling or shading:

- Add the following symbols to indicate the type of pain in each area:

A-Aching **B**-Burning **N**-Numbness **P**-Pins & Needles **S**-Sharp or stabbing **T**-Throbbing



Please describe the problem(s) that you wish to see the doctor for, please include:

- **When and how it started** (i.e.: 10 years ago, fell down the stairs)
- **What treatments** you have received for this condition (manipulation, chiropractic, physical therapy, injections, or surgeries)
- **What tests or studies** you have had for this condition (x-rays, CT, MRI, bone scan, EMG) and the results of the tests.)

_____

_____

_____

_____

_____

_____

Please mark on the lines below indicating the LEVEL OF YOUR PAIN (if applicable)

O =LEAST **X**=MOST /=today

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

What INCREASES your pain?

1)_____

2)_____

3)_____

What RELIEVES your pain?

1)_____

2)_____

3)_____

What do you currently do for **EXERCISE**:

_____

_____

ALLERGIES:

Are you aware of any allergies to any medications? _____Yes _____No
Please list any medications you are allergic to and the reaction you had to them:

_____

_____

MEDICATIONS & SUPPLEMENTS:

Please list each drug that you take (including non-prescription drugs such as aspirin, Tylenol, herbs, vitamins and supplements), its dose and how often you take it:

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY:

When was your last complete check-up/physical? _____

Who is your Primary Doctor? _____

Please list any MEDICAL PROBLEMS you have:

_____

_____

_____

_____

_____

Please list any TRAUMA you have had (including childhood falls, work injuries, sports injuries, etc.) in which you were sore for at least several days:

_____

_____

_____

_____

Have you ever HIT YOUR HEAD? _____Yes _____No
Have you ever LOST CONSCIOUSNESS from a head injury? _____Yes _____No

Please list any OPERATIONS you have had (include dental work):

_____

_____

_____

Please list any HOSPITALIZATIONS you have had (include childbirths):

_____

_____

SOCIAL HISTORY:

Are you: Single Married Divorced Widowed Committed Relationship (please circle)
How many children do you have? _____
Usual occupation: _____
Are you currently working? _____Yes _____No
Are you limited at work because of disability? _____Yes _____No
Do you have problems performing your day-to-day activities? _____Yes _____No

Personal Habits

Yes No Current smoker or tobacco user
Amount smoked/chewed per day:_____
Type: _____Cigarettes _____Pipe _____Cigars _____Chewing Tobacco

Yes No Smoked in past
When did you quit? _____ # of years you smoked: ____
Amount smoked per day ___

Yes No Caffeine use: coffee, tea, soda, chocolate (please circle)
Amount: _____ Frequency: _____

Yes No Alcoholic beverages: beer, wine, liquor (please circle)
Amount: _____ Frequency: _____

Yes No Diet Soda
Amount: _____ Frequency: _____

What is your usual diet?

Breakfast	Lunch	Dinner	Snacks

Are you vegetarian? _____Yes _____No Are you happy with your weight? _____Yes ____No
Are there foods that you avoid?_____ Yes _____ No

_____

Additional Notes:

_____
_____
_____
_____
_____
_____

REVIEW OF SYSTEMS

Please check if you have had any of the following in the **past month**:

General

Fatigue _____
Fever, Chills _____
Loss of appetite _____
Weight gain _____
Weight loss _____
Low body temperature _____

Sleep

Difficulty falling asleep at night _____
Difficulty staying asleep at night _____
Do not feel refreshed on waking _____
Average sleep per night: _____hours

Joints

Joint stiffness in the morning _____
Joint pain at night _____
Perception of heat in joints _____
Do you have a short leg _____
Do you wear a heel lift _____
Do you wear orthotics _____

Head and Neck

Dry eyes _____
Dry mouth _____
Hearing loss _____
Ringing in ears (tinnitus) _____
Wear a bite splint or retainer _____
Jaw clicks or pops _____

Chest and Abdomen

Shortness of Breath _____
Asthma _____
Diarrhea _____
Constipation _____
Nausea or vomiting _____
Heartburn _____
Abdominal pain _____

Urine

History of urine infections _____
Pain when urinating _____
Unable to hold urine _____
Urinate often (less than 2 hrs) _____

Men

Prostate problems _____

Women

Irregular menstruation _____
Painful menstruation _____
Painful intercourse _____
Difficulty conceiving _____

Endocrine

Cold/Heat intolerance _____
Brittle nails _____
Dry hair _____
Difficulty losing weight _____

Neurological

Headaches _____
Migraines _____
Memory loss _____
Muscle weakness _____
Numbness or tingling _____
Seizures _____

Psychological

Anxiety _____
Depression _____
Overwhelming sadness _____
Thoughts of taking your life _____

Other Symptoms:

_____
_____
_____
_____
_____
_____
_____

Family History	✓	Who?
Cancer	_____	_____
Diabetes	_____	_____
Fibromyalgia	_____	_____
Heart Disease	_____	_____
Osteoporosis	_____	_____
Thyroid Disease	_____	_____

_____
_____
_____