

PATIENT HEALTH HISTORY



Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____

Referring Physician: _____ Primary/Family Physician: _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Do you smoke?	YES	NO	Are you sensitive to latex?	YES	NO
Do you have a pacemaker?	YES	NO	Females: Are you currently pregnant or think you might be pregnant?	YES	NO

Have you RECENTLY noted any of the following (check all that apply)?

- | | | |
|---|--|--|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> constipation |
| <input type="checkbox"/> fever/chills/sweats | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> fainting |
| <input type="checkbox"/> falls | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> cough |
| <input type="checkbox"/> difficulty maintaining balance/walking | <input type="checkbox"/> changes in bowel/bladder function | <input type="checkbox"/> headaches |

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|---|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chest pain/angina | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Other arthritic condition | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Bladder/urinary tract infection | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eye irritation/infection | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Sexually transmitted disease/HIV | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Recent infection | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Other: |

Have you had any prior surgeries? If yes, please explain: _____

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

Please list any allergies (including medications): _____

Name _____

Account _____

Have you had any of the following for your current problem: X-Ray Injection MRI CT Scan

Are you currently being treated by a chiropractor? YES NO

Are you on a work restriction from your doctor? YES NO

Date of Injury or Surgery: _____ Body Part Affected: _____

What do you think caused your symptoms? _____

Have you ever had this problem before? YES NO If yes, when? _____ Treatment received _____

How long did it take for you to feel better? _____

Body Chart: Please mark the areas on the chart to the right with the following symbols to describe your current symptoms:

↓ Shooting/sharp pain ξξξ Numbness O Dull/aching pain = Tingling

My symptoms: Come and go Are Constant Are constant, but change with activity

Aggravating Factors: identify positions or activities that make your symptoms worse:

Easing Factors: Identify positions or activities that make your symptoms better:

How are you currently able to sleep at night due to your symptoms?

No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms **worst**? Morning Afternoon Evening Night After exercise

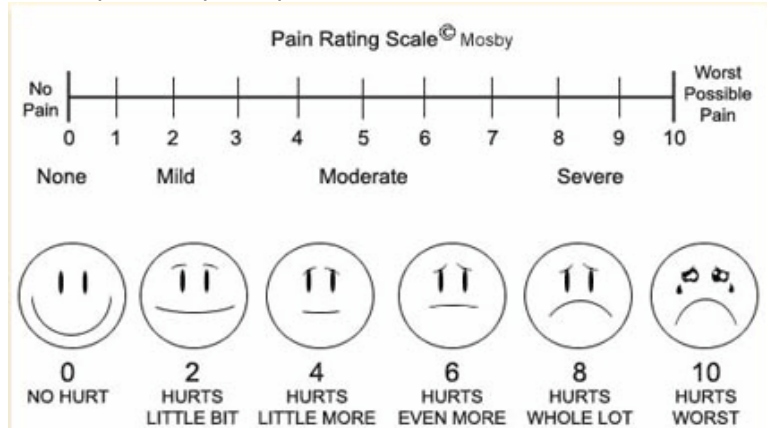
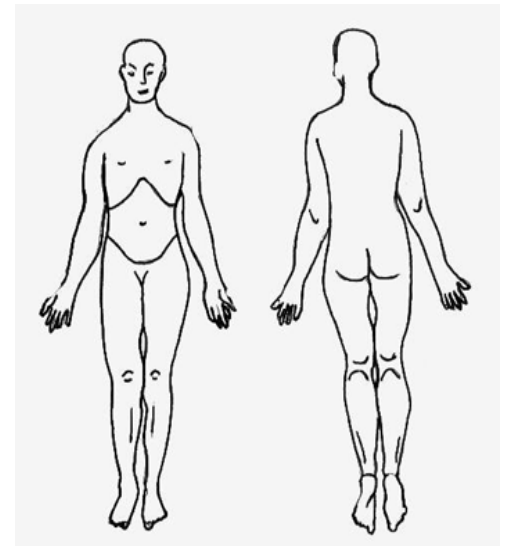
When are your symptoms **best**? Morning Afternoon Evening Night After exercise

Using the 0 to 10 scale, with 0 being “no pain” and 10 being the “worst possible pain,” please describe:

Your CURRENT level of pain while completing this survey:

The BEST your pain has been during the past 24 hours:

The WORST your pain has been during the past 24 hours:



Name _____

Account _____