Patient History Form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Gender: M / F / N | How would you rate your general health? Excellent Good Fair Poor |
| Date of birth: | Do you exercise at least 3 times/week? Y / N |
| Smoker: Yes / No | Past surgeries: (list & date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Pregnant: Yes / No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Occupationr: | Current medications (prescription, over-the-counter): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Past Medical History: Have you ever been told you have any of the following?**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Cancer | Yes | No |  | Ulcers | Yes | No |
| Heart problems | Yes | No |  | Infectious diseases | Yes | No |
| High Blood Pressure | Yes | No |  | Lung problems | Yes | No |
| Angina/Chest Pain | Yes | No |  | Hepatitis | Yes | No |
| Asthma | Yes | No |  | Anemia | Yes | No |
| Diabetes | Yes | No |  | Allergies | Yes | No |
| Osteoporosis | Yes | No |  | Fibromyalgia | Yes | No |
| Thyroid problems | Yes | No |  | Kidney disease | Yes | No |
| Rheumatoid arthritis | Yes | No |  | Stroke | Yes | No |
| Osteoarthritis | Yes | No |  | Seizures/Epilepsy | Yes | No |
| Depression | Yes | No |  | Other |  |  |

**Currently, are you experiencing any of the following? (circle all that apply):**

Fever/chills/sweats Poor balance (falls) Unexplained weight loss

Numbness/tingling Changes in appetite Difficulty swallowing Pelvic pain

Depression Shortness of breath Changes in bowel or bladder function

Dizziness Nausea/vomiting Night pain Headaches

How have you been sleeping at night? Fine Disturbed only with medication

During the past month, have you been bothered by feeling down, depressed or hopeless? Y / N

During the past month, have you had little interest or pleasure in doing things? Y / N

**Current History**:

What date (approximately) did your present symptoms start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How? (gradually, suddenly, injury) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

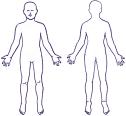
How have your symptoms changed? getting better about the same getting worse

What makes your symptoms better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your symptoms worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had an x-ray, MRI, or other testing for this problem? No / Yes (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What treatments have you received for this problem so far? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Body Chart:**

Mark the areas where

you feel your symptoms.

On the scale below, circle the number which best represents the average level of pain you have experienced over the last 48 hours:

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

Circle the number below which best represents your overall average level of function:

0 1 2 3 4 5 6 7 8 9 10

Cannot do Able to do

anything everything

**Aggravating Factors**: Identify up to 3 important activities that you are unable to do or have difficulty with as a result of your problem.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

During the past 3 months, have you seen any medical professional (doctor, chiropractor, PT,

osteopath, etc)? Yes / No If yes, please describe the reason. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any other injuries you have had that required medical attention. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your personal goals for therapy at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSENT: My diagnosis and treatment plan will be discussed during my appointment and I understand that I have the right to question and/or refuse any treatment offered. The information I have provided above is accurate and complete. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_sign \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date