~ PATIENT HISTORY ~

name:______________________________ email: ______________________________

address: ________________________ city:________________ state: _____ zip: ________

phone: ______________ age: _____ birthdate: ____________ gender: ____

marital staus: M S W D children: _____

Whom may we thank for referring you? : ___________________________

occupation: ___________________ employer: ___________________________

work phone: ____________________ years employed: _____________

spouse's name: _________________ occupation: ____________ work #: ______________

person responsible for account: ____________________________________

What is your major complaint? ____

other complaints? ____

Date condition started: _______________ Date of similar conditions in past? ___________

What aggravates this condition? ____

Is this condition getting progressively worse? ☐ yes ☐ no ☐ constant ☐ comes & goes

List any surgical operations: ____

Currently taking medication? Y / N What kind? _______________________________

Any non-prescription drugs? Y / N what kind? ________________________________

other doctors seen for this conditon? MD DC DO DDS

Doctor's Name: _______________________ Diagnosis: _______________________

X-rays _______ Urinalysis ______ Blood tests______ Other ___________________

Treatment: medication _______________ physiotherapy ___________________________

Results:_____________________________ Length of time under care: _______________

Were you off work? Y / N if so, how long? _________ returned to same job? Y / N

if not, why? _____________________________

ACCIENT INFORMATION:

Did your accident occur while at work? Yes No Did you report it? Yes No

Date:____________ Time: ______________

Description: ____

**** if work-related accident, please notify front desk for additional forms ****

Involving an automobile accident? Yes No Police report filed? Yes No

Date:____________ Time: ______________

Description: ____

I clearly understand and agree that all services rendered to me are my personal responsibility. If this office files an insurance claim on my behalf, I understand that I will be responsible for any deductible and/or co-pay(s) that apply as outlined by my insurance company's policy.

Patient's Signature: ____________________________________ Date: ________________

IMPORTANT: Please check (X) all present symptoms.

HEAD:
- ☐ Headache
  - ☐ sinus (allergy)
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

SHOULDERS:
- ☐ Pain in shoulder joint (R · L)
- ☐ Pain across shoulders
- ☐ Bursitis (R · L)
- ☐ Arthritis (R · L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R · L)
- ☐ Muscle spasms in shoulders

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Numbness in arms (R · L)
- ☐ Numbness in fingers (R · L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

MID-BACK:
- ☐ Mid-back pain
- ☐ Location ______________________
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull Ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Dimpled or orange peel breast
- ☐ Irregular heartbeat

ABDOMEN:
- ☐ Nervous stomach
- ☐ Foods can't eat ______________
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

LOW BACK:
- ☐ Low back pain
  - ☐ Upper lumbar
  - ☐ Lower lumbar
  - ☐ Sacroilliac
- ☐ Low back pain is worse when:
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
  - ☐ lying down (sleeping)
  - ☐ walking
- ☐ Pain relieves when ______________
- ☐ Slipped disk
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

HIPS, LEGS & FEET:
- ☐ Pain in buttocks (R · L)
- ☐ Pain in hip joint (R · L)
- ☐ Pain down leg (R · L)
- ☐ Pain down both legs
- ☐ Knee pain
  - ☐ Inside
  - ☐ Outside
- ☐ Leg cramps
- ☐ Cramps in feet (R · L)
- ☐ Pins & needles in legs (R · L)
- ☐ Numbness of leg (R · L)
- ☐ Numbness of feet (R · L)
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Swollen ankles (R · L)
- ☐ Swollen feet (R · L)

WOMEN ONLY:
- ☐ Menstrual pain ______________ (where)
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle ______ days
- ☐ Birth control ______________ (type)
- ☐ Hysterectomy
- ☐ Genital cancer ______________ ___
- ☐ Discharge
- ☐ Menopause ______________
- ☐ Tumors
- ☐ Abortions
- ☐ Are you or do you think you are pregnant?

MEN ONLY:
- ☐ Urinary frequency
- ☐ Difficulty in starting
- ☐ Night urination
- ☐ Prostate pain/swelling

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep ______
- ☐ Loss of sleep ______ hrs./night
- ☐ Loss of weight ______ lbs.
- ☐ Gain weight ______ lbs.
- ☐ Coffee ______ cups/day
- ☐ Tea ______ cups/day
- ☐ Cigarettes ______ pack/day
- ☐ Other ______________________
- ☐ Diabetes
- ☐ Hypoglycemia

REMARKS:

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