

Patient History

Name: _____ Date: _____

Mailing Address: _____
number and street city state zip code

Email Address: _____

Home Telephone: _____ Cell Telephone: _____

Date of Birth: _____ Age: _____ Gender: M F
mm dd yyyy

Marital Status: M S W D Number of Children: _____

Name of Spouse: _____ Telephone: _____

Your Occupation: _____ Employer: _____

Work Telephone: _____ Please circle number to use for telephone reminders

Whom may we thank for referring you to this office? _____

Person responsible for account: _____

What is your major complaint? _____

Date major complaint began: _____
mm dd yyyy

Is this condition becoming progressively worse? _____

Other complaints? _____

List surgical operations with dates: _____

Are you taking medication? _____ If so, please list name(s) and describe purpose: _____

Do you use non-prescription drugs? _____ If so, please list the name(s): _____

Patient Signature: _____ Doctor's Initials: _____

Please check 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/buzzing in ears
- other:

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/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 (R L)
- 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 fingers: in arms
- numbness in arms (R L)
- numbness in fingers
- 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
- irregular heartbeat

ABDOMEN:

- nervous stomach
- foods can't eat _____
- nausea
- gas
- constipation
- diarrhea
- hemorrhoids

LOW BACK:

- low back pain
 - upper lumbar
 - lower lumbar
 - sacroiliac
- low back pain is worse when:
 - walking
 - working
 - lifting
 - stooping
 - standing
 - sitting
 - bending
 - coughing
 - lying down (sleeping)
- 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)
 - of feet (R L)
 - of toes (R L)
- feet feel cold
- swollen ankles (R L)
- swollen feet (R L)

Patient Signature: _____

Doctor Initials: _____

WOMEN ONLY:

- menstrual pain
- cramping
- irregular cycle
- hysterectomy (when) _____
- are you or do you think you are pregnant? _____

MEN ONLY:

- urinary frequency
- difficulty in starting
- night urination
- prostate pain/swelling

GENERAL:

- nervousness
- irritability
- depression
- fatigue
- generally feel run-down
- loss of sleep (hrs/night) _____
- loss of weight _____ lbs
- gain weight _____ lbs
- coffee _____ cups/day
- tea _____ cups/day
- cigarettes _____ pack/day
- diabetes
- hypoglycemia
- other

Other Information:

I have read and completed the information on pages 1 & 2 of this form and it is true and correct.

I understand and agree that I am financially responsible for all services rendered to me. If this office files an insurance claim on my behalf I understand and agree that I will be responsible for payment of any deductible and/or co-pay amounts that apply as outlined by my insurance company's policy and plan.

Date: _____

Date: _____