Initial Patient History

Visit date:______________

Name:_______________________________________
Age:________
Sex: Male / Female Left / Right Handed
Primary Care Physician:________________________

SYMPTOMS: *(Please circle all that apply)*
Back pain Neck pain Arm pain Leg pain
Other:____________________________

The pain has been present for……
0-1 week **6-12 months**
1-4 weeks **1-3 years**
4-8 weeks **3+ years**
3-6 months

Does the pain radiate to…..**an arm? Right / Left**
a leg? Right / Left

Do you have weakness in….**an arm? Right / Left**
a leg? Right / Left

Do you have numbness in…**an arm? Right / Left**
a leg? Right / Left

Did you have an injury? **Yes / No**
At work? **Yes / No**
Motor vehicle accident? **Yes / No**
Other injury:_____________________________
Date of injury:____________________________

Any loss in your bladder or bowel control? **Yes / No**
Does your pain wake you up at night? **Yes / No**

What relieves your pain?
Lying down Sitting Walking Bending
Other:_________________________________

What makes your pain worse?
Lying down Sitting Walking Bending
Other:_________________________________

Does your pain limit your ability to function? **Yes / No**
If yes, please describe_________________________
____
____
____
____

Are you independent in normal daily activities? **Yes / No**
Has this changed recently? **Yes / No**

Who do you live with? (Please include ages)
____
____
____
____

Have you had any major life changes recently? **Yes / No**
If so, please explain_______________________________
____
____

PRIOR INJURIES/TRAUMA:
Have you experienced any major losses in your life? **Yes / No**
If yes, please explain______________________________
____
____
____
____

Have you had any bodily injuries in your life including fractures, falls? **Yes / No**
If yes, please explain______________________________
____
____
____
____

To your knowledge, did you have a traumatic birth? **Yes / No**
If yes, please explain______________________________
____
____
____

TREATMENT HISTORY:
(Have you had any of the following for your pain?)
Medications? **Yes / No**
If yes, names?___________________________________
____
Physical therapy? **Yes / No**
Injections? **Yes / No**
If yes, what type_________________________________
Chiropractic? **Yes / No**
Counseling? **Yes / No**
Other? Please list______________________________
____
____

Names of treating doctors:________________________
____

What diagnostic tests have you had?

X-ray **Bone scan** **Myelogram**
MRI **Discogram** **CT scan**
Nerve study/EMG

PAST MEDICAL HISTORY:
(Do you have any of the following medical problems?)

AIDS/ HIV	Yes/No	Drug abuse	Yes/No
Arthritis	Yes/No	Bleeding Probs	Yes/No
Cancer	Yes/No	Diabetes	Yes/No
Asthma	Yes/No	Depression	Yes/No
Lung disease	Yes/No	Epilepsy	Yes/No
Fibromyalgia	Yes/No	Gout	Yes/No
Headaches	Yes/No	Heart disease	Yes/No
Hepatitis	Yes/No	High blood press	Yes/No
Kidney problems	Yes/No	Muscle disease	Yes/No
Osteoporosis	Yes/No	Polio	Yes/No
Psychiatric d/o	Yes/No	Stomach ulcers	Yes/No
Chronic heartburn	Yes/No	Stroke	Yes/No
Thyroid problems	Yes/No	Alcohol abuse	Yes/No

Other:_______________________________________
____

PAST SURGICAL HISTORY:
(Please list any previous surgeries with dates)
____
____
____
____

OCCUPATIONAL HISTORY:
Occupation:__________________________________
Employer:___________________________________
How long at your current job?_______months / years
Which of the following best describes you currently?

Working full time **Working part-time**
Homemaker **Unemployed**
Disabled **Retired**
Not working due to pain

Time lost from work?_______Days/Wks/Mos/Years

ALLERGIES:
(To medications, food, or environmental)
____
____
____
____

CURRENT MEDICATIONS/SUPPLEMENTS:
(Please list all medications including over-the-counter,herbal & any supplements)
____
____
____
____
____
____

SOCIAL HISTORY:
Current Marital status: Single/ Married/ Partner Divorced/ Widowed
Do you smoke tobacco? Yes / No
If yes, amount_____ packs per day/ wk
Do you drink alcohol? Yes / No
If yes, amount _____beers per day/ wk
_____shots per day/wk
Do you use any recreational drugs? Yes / No
If yes, type___________________________
Are you currently on a special diet? Yes / No
If yes, type___________________________
Do you exercise regularly? Yes / No
If yes, specify_________________________
____
____
What do you enjoy doing in your spare time?
____
____
____

FAMILY HISTORY: *(Does any member of your family have a history of.....)*

AIDS/ HIV	Yes/No	Drug abuse	Yes/No
Arthritis	Yes/No	Bleeding Probs	Yes/No
Cancer	Yes/No	Diabetes	Yes/No
Asthma	Yes/No	Depression	Yes/No
Lung disease	Yes/No	Epilepsy	Yes/No
Fibromyalgia	Yes/No	Gout	Yes/No
Headaches	Yes/No	Heart disease	Yes/No
Hepatitis	Yes/No	High blood press	Yes/No
Kidney probs	Yes/No	Muscle disease	Yes/No
Osteoporosis	Yes/No	Psychiatric d/o	Yes/No
Stomach ulcers	Yes/No	Stroke	Yes/No
Thyroid probs	Yes/No	Alcohol abuse	Yes/No

Other:_______________________________________
____

REVIEW OF SYSTEMS: *(Do you currently have any of the following symptoms?)*

Abnormal bleeding	Yes / No
Cold hands/feet	Yes / No
Constipation	Yes / No
Depression	Yes / No
Anxiety/ Panic attacks	Yes / No
Extreme fatigue	Yes / No
Fever, chills	Yes / No
Muscle spasms	Yes / No
Shortness of breath	Yes / No
Skin rashes	Yes / No
Sleep disturbance	Yes / No
Stomach pain	Yes / No
Recent weight gain	Yes / No

REVIEW OF SYSTEMS (*continued*)

Unexplained weight loss	Yes / No	Ringing ears	Yes / No
Swelling of the legs	Yes / No	Restless legs	Yes / No
Irritability	Yes / No	Diarrhea	Yes / No
Impaired concentration	Yes / No	Gas/bloating	Yes / No
Sugar cravings	Yes / No	Bladder infections	Yes / No
Dizziness	Yes / No	Brittle nails	Yes / No
Wear glasses or contacts	Yes / No	Chest pain	Yes / No
Other:_______________________________________		Leg cramps	Yes / No

____
____

LOCATION OF PAIN/ PROBLEM:
(Please place X's on figure for pain location)

SEVERITY OF PAIN:
(Please circle ONE)

1	2	3	4	5	6	7	8	9	10
	MILD			MODERATE			SEVERE		

Thank you for taking the time to complete this Health Questionnaire.

I certify that I have completed the above 3 pages of health information to the best of my ability and that the information is true.

______________________________________ ___________________

Patient Signature ***Date***

All Forms reviewed on:

By: