Patient History Form

Name: ____ Date: _________________

Appointment date: _________________

Current age: _________________

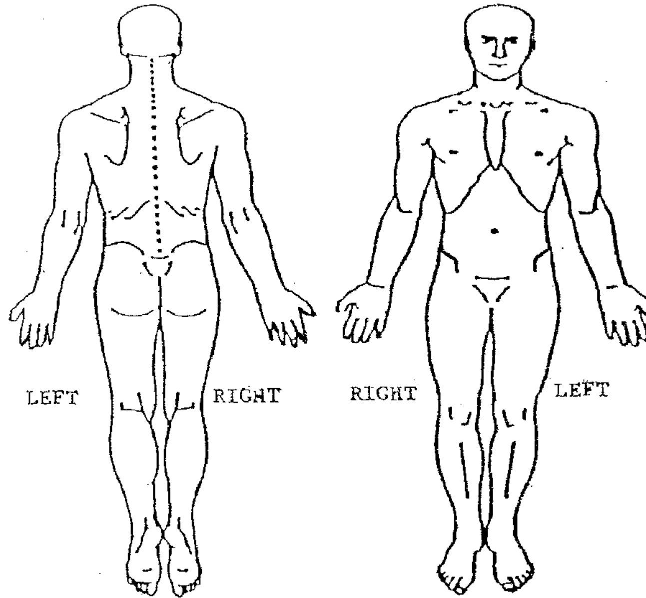
SYMPTOM DIAGRAM

Current Pain Location – Indicate on drawing by circling or shading:

- Add the following symbols to indicate the type of pain in each area:

A-Aching **B**-Burning **N**-Numbness **P**-Pins & Needles **S**-Sharp or stabbing **T**-Throbbing

- If shooting pain is present, put in arrows to indicate direction



Please describe the problem(s) that you wish to see the doctor for, please include:

- **When and how it started** (i.e.: 10 years ago, fell down the stairs)
- **What treatments** you have received for this condition (manipulation, chiropractic, physical therapy, injections, or surgeries)
- **What tests or studies** you have had for this condition (x-rays, CT, MRI, bone scan, EMG) and the results of the tests.) **Please bring all recent Lab Results and X-ray Reports to your first appointment.**

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Please mark on the lines below indicating the LEVEL OF YOUR PAIN (if applicable)

O =LEAST **X**=MOST /=today

(no pain) 0---1---2---3---4---5---6---7---8---9---10 (severe pain)

What INCREASES your pain?

1)______________________________

2)______________________________

3)______________________________

What RELIEVES your pain?

1)______________________________

2)______________________________

3)______________________________

What do you currently do for **EXERCISE**:

____

____

____

ALLERGIES:

Are you aware of any allergies to any medications? _____Yes _____No

Please list any medications you are allergic to and the reaction you had to them:

____

____

____

MEDICATIONS & SUPPLEMENTS:

Please include every Drug or Supplement that you take, it's DOSE and how often you take it (ie: Tylenol 375mg 1xday, Turmeric 500mg 2xday)

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

MEDICAL HISTORY:

When was your last check-up/physical? _____________Doctor: ___________________

Please list any MEDICAL PROBLEMS you have:

____

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____

____

Please list any SURGERIES/OPERATIONS you have had (include dental work):

____

____

____

Please list any HOSPITALIZATIONS you have had (include childbirths):

____

____

____

Please describe your own birth (if you know about it):

____

____

Please list any TRAUMA you have had (including childhood falls, work injuries, sports injuries, etc.) in which you were sore for at least several days:

____
____
____
____
____
____

Have you ever fallen straight down on your bottom? ______Yes ______ No
Have you ever HIT YOUR HEAD? _____Yes _____No
Have you ever LOST CONSCIOUSNESS from a head injury? _____Yes _____No

SOCIAL HISTORY:

Are you: Single Married Divorced Widowed Committed Relationship (please circle)
How many children do you have? girls_________ boys__________
Usual Occupation: ____
Are you currently working? _____Yes _____No
Are you limited at work because of disability? _____Yes _____No
Do you have problems performing your day-to-day activities? _____Yes _____No

Personal Habits

Yes No Current smoker or tobacco user
Amount smoked/chewed per day:______
Type: _____Cigarettes _____Pipe _____Cigars _____Chewing Tobacco
Yes No Smoked in past
When did you quit? _____ # of years you smoked: ____
Amount smoked per day ___
Yes No Caffeine use: coffee, tea, soda, chocolate (please circle)
Amount: _____________ Frequency: _____________
Yes No Alcoholic beverages: beer, wine, liquor (please circle)
Amount: _______________ Frequency: _____________
Yes No Diet Soda
Amount: _______________ Frequency: _____________

What is your usual diet?

Breakfast	Lunch	Dinner	Snacks
__________	__________	__________	__________
__________	__________	__________	__________
__________	__________	__________	__________

Are you vegetarian? _____Yes _____No Are you happy with your weight? _____Yes ____No
Are there foods that you avoid?_______ Yes _______ No

____

REVIEW OF SYSTEMS

Please check if you have had any of the following in the **past month**:

General

Fatigue ______
Fever, Chills ______
Loss of appetite ______
Weight gain ______
Weight loss ______
Low body temperature ______

Sleep

Difficulty falling asleep at night ______
Difficulty staying asleep at night ______
Do not feel refreshed on waking ______
Average sleep per night: ________hours

Joints

Joint stiffness in the morning ______
Joint pain at night ______
Perception of heat in joints ______
Do you have a short leg ______
Do you wear a heel lift ______
Do you wear orthotics ______

Head and Neck

Dry eyes ______
Dry mouth ______
Hearing loss ______
Ringing in ears (tinnitus) ______
Wear a bite splint or retainer ______
Jaw clicks or pops ______

Chest and Abdomen

Shortness of Breath ______
Asthma ______
Diarrhea ______
Constipation ______
Nausea or vomiting ______
Heartburn ______
Abdominal pain ______

Urine

History of urine infections ______
Pain when urinating ______
Unable to hold urine ______
Urinate often (less than 2 hrs) ______

Men

Prostate problems ______

Women

Irregular menstruation ______
Painful menstruation ______
Painful intercourse ______
Difficulty conceiving ______

Endocrine

Cold/Heat intolerance ______
Brittle nails ______
Dry hair ______
Difficulty losing weight ______

Neurological

Headaches ______
Migraines ______
Memory loss ______
Muscle weakness ______
Numbness or tingling ______
Seizures ______

Psychological

Anxiety ______
Depression ______
Overwhelming sadness ______
Thoughts of taking your life ______

Other Symptoms:

____
____
____
____
____
____
____

Family History	✓	Who?
Cancer	______	________________
Diabetes	______	________________
Fibromyalgia	______	________________
Heart Disease	______	________________
Osteoporosis	______	________________
Thyroid Disease	______	________________
Scoliosis	______	________________

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