PATIENT HISTORY

Patient Name: ____

Main reasons for contacting us: ____

When did it start? ____/____/____. It started: ○ Suddenly ○ Gradually

Is this condition getting worse? ○ Yes ○No

Does this condition interfere with your ○ Work ○ Sleep ○ Daily activity

What seems to bring on your condition? ______________________________________

What makes it feel worse? ______________________ Better? ______________________

Describe your condition:

○ Constant 100% ○ Frequent 75% ○ Intermittent 50% ○ Occasional 25% ○ Rare 10%
○ Sharp ○ Dull ○ Aching ○ Burning ○ Numb
○ Localized ○ Radiating to:______________________

How bad is your pain? (circle 0 for no pain to 10 unbearable) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Other doctors seen for this condition:

Date	Name	Tests/Treatments	Results

Please list all SURGERIES, ACCIDENTS & FALLS, FRACTURES & DISLOCATIONS

Type______________________ When_______ Type______________________ When_______

Type______________________ When_______ Type______________________ When_______

Please list any medications and/or vitamins you take

What______________________dosage:_______ What______________________dosage:_______

What______________________dosage:_______ What______________________dosage:_______

Health Habits: How much per day or week?

Exercise: 1) Type______________ Frequency__________ 2) Type______________ Frequency__________

Sleep: Hours per night__________ ○ Good ○ Fair ○ Poor / ○ Back ○ Side ○ Stomach

Family History: Have you or anyone in your family ever had

○ High blood pressure ○ Cholesterol ○ Diabetes ○ Heart disease ○ Stroke ○ Asthma ○ Dizziness ○ Thyroid

○ Kidney disease ○ Indigestion ○ Abdominal pain ○ Cancer ○ Arthritis ○ Weight gain ○ Other__________

Occupational Information: Job involves:

○ Sitting ○ Standing How long________/__________ ○ Lifting How much weight____________

Do any of your work activities aggravate your present main complaints? Please describe____________________

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

______________________________ ____________________
Patient Signature Date