PATIENT HISTORY FORM

Name:_____ **DOB:**_____ **Date:**_____

Reason for your visit: _____

List one or two daily activities that are limited/reduced/eliminated by your symptoms:

_____

How long have you had symptoms:_____ **Date these problems began:** _____

What reduces the pain?

☐ **Sleeping** ☐ **Standing** ☐ **Ice** ☐ **Heat** ☐ **Stretching** ☐ **Sitting** ☐ **Rest** ☐ **Treatment** ☐ **NSAIDS**
☐ **Pain Medication** ☐ **Other**_____

What activities make it worse?

☐ **Sleeping** ☐ **Standing** ☐ **Sitting** ☐ **Lifting** ☐ **Time on Computer** ☐ **Talking on Phone** ☐ **Walking**
☐ **Running** ☐ **Sneezing/Coughing** ☐ **Bending** ☐ **Working** ☐ **Driving** ☐ **Stairs** ☐ **Palpation**
☐ **Changing Positions** ☐ **Other**_____

Do you have any allergies to medications (if so, please list):_____

Are you currently taking any medications? ☐ YES ☐ NO If yes, please list including dosage and times per day.

Name	**Dose**	**x Per Day**	**Name**	**Dose**	**x Per Day**

Woman: Are you or were you taking birth control? ☐ Yes ☐ No For How Long _____

Are you currently pregnant? ☐ Yes ☐ How Many Weeks _____

PAST SURGICAL HISTORY

Have you ever had any surgeries including spine surgery? ☐ Yes ☐ No

If yes, please give the dates and type of operation.

DATE **SURGERY**

_____

_____

_____

HISTORY OF ILLNESS IN YOUR FAMILY

F-Father M-Mother B-Brother S-Sister So- Son D- Daughter HS- Half Sibling

Stroke/TIA	☐ Yes ☐ No	Who:_____	Diabetes (1 or 2)	☐ Yes ☐ No	Who:_____
High Cholesterol	☐ Yes ☐ No	Who:_____	Heart Attack	☐ Yes ☐ No	Who:_____
Rheumatoid Arthritis	☐ Yes ☐ No	Who:_____	Cancer	☐ Yes ☐ No	Who:_____
High Blood Pressure	☐ Yes ☐ No	Who:_____			

Other:_____

SOCIAL HISTORY

Please note the following and note the amount used:

Cigarettes: How many packs per day _____ How many years smoked _____ If you stopped smoking, when did you quit _____

Alcohol: (Circle) ☐Beer ☐ Wine ☐Mixed drinks How many per day_____ per week _____

PAST MEDICAL HISTORY-*Indicate if you currently have, or previously suffered from:*

Allergic-Immunologic:

☐ Hives/Eczema ☐ Hay Fever ☐ Catch Colds Easily ☐ Frequent Sinus Trouble ☐ Frequent Influenza
☐ HIV ☐ Aids ☐ Allergies ☐ Fever

Cardiovascular:

☐ Murmur ☐ Chest Pain ☐ Palpitations ☐ Dizziness ☐ Shortness Of Breath
☐ Swollen Ankles ☐ Heart Attack ☐ Irregular Heart Beat ☐ Pressure Over The Chest ☐ Pain Down The Left Arm
☐ High Triglycerides ☐ High Cholesterol Levels ☐ Profuse Sweating ☐ Nausea ☐ Vomiting
☐ Low Blood Pressure ☐ Fainting Spells ☐ High Blood Pressure ☐ Difficulty Lying Flat

Constitutional:

☐ Weight Loss ☐ Fatigue ☐ Fever

Ear, Nose, Throat:

☐ Difficulty Hearing ☐ Buzzing In Ears ☐ Ringing In Ears ☐ Vertigo ☐ Sinus Trouble ☐Nasal Stuffiness
☐ Hearing Loss ☐ Ear Pain ☐ Mouth Sores ☐ Hoarseness ☐ Nose Bleeds ☐Dental Problem
☐ Frequent Sore Throat ☐ Difficulty Swallowing

Endocrine:

☐ Loss Of Hair ☐ Heat/Cold Intolerance ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes ☐Goiter

Eyes:

☐ Glasses/Contacts ☐ Eye Pain ☐ Light Bothers Eyes ☐ Double Vision ☐ Cataracts ☐Vision Problems
☐ Blurred Vision ☐ Glaucoma

Gastro-Intestinal:

☐ Heartburn/Reflux ☐ Nausea/Vomiting ☐ Constipation ☐ Change In Bms ☐ Diarrhea
☐ Black Or Bloody Bm ☐ Gallbladder Problem ☐ Liver Problem ☐ Hepatitis ☐ Distress From Greasy Food
☐ Ulcers ☐ Heartburn ☐ Hiatal Hernia ☐ Colitis ☐ Blood In The Stool
☐ Colon Cancer ☐ Abdominal Pain ☐ Burning In Stomach ☐ Pancreatitis ☐ Jaundice
☐ Pain Over Stomach ☐ Mucus In Stool

Genitourinary:

☐ Burning/Frequency ☐ Blood In Urine ☐ Erectile Dysfunction ☐ Abnormal Discharge ☐ Leakage ☐Incontinence
☐ Kidney Infection ☐ Sexual Difficulty ☐ Kidney Stones ☐ Loss Of Libido

Hematology/Lymph:

☐ Easy Bruising ☐ Gums Bleed Easily ☐ Enlarged Glands ☐ Anemia ☐ Bleeding Disorder ☐Sickle Cell Anemia
☐ Lymphoma

Musculoskeletal:

☐ Joint Pain/Swelling ☐ Stiffness ☐ Muscle Pain ☐ Neck Pain ☐ Stiff Neck ☐Back Pain
☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Bone Spurs ☐ Broken Bones ☐ Compression Fracture ☐Head Injury
☐ Back Injury ☐ Spinal Trauma ☐ Birth Trauma ☐ Birth Defects ☐ Cancer ☐Muscle Weakness
☐ Muscular Dystrophy ☐ Scheuerman's Disease ☐ Scoliosis ☐ Lupus ☐ Spina Bifida ☐Spondylolisthesis
☐ Arthritis ☐ Neck Injury ☐ Osteoporosis

Neurological:

☐ Loss Of Strength ☐ Numbness ☐ Headaches ☐ Heavy Head ☐ Tremors ☐Memory Loss
☐ Difficulty Speaking ☐ Multiple Sclerosis ☐ Parkinson's Disease ☐ Fainting ☐ Concussion ☐Migraines
☐ Disorientation ☐ Loss Of Coordination ☐ Difficulty In Walking ☐ Stroke ☐ Alzheimer's Disease ☐ Weakness
☐ Disk Problem ☐ Light Headed /Dizzy ☐ Epilepsy / Seizures ☐ Tingling

Psychiatric:

☐ Anxiety ☐ Depression ☐ Mood Swings ☐ Difficult Sleeping ☐ Nervousness ☐ Tension

Respiratory:

☐ Cough ☐ Coughing Blood ☐ Wheezing ☐ Chills ☐ Chronic Cough ☐ Pneumonia
☐ Asthma ☐ Superficial Breathing ☐ Chest Pain ☐ Tuberculosis ☐ Bronchitis ☐ Emphysema
☐ Difficulty Breathing ☐ Lung Cancer

Skin:

☐ Rash/Sores ☐ Lesions ☐ Itching/Burning ☐ Skin Problem ☐ Slow Healing ☐ Bruise Easily
☐ Psoriasis ☐ Change In Moles ☐ Change In Skin Color ☐ Skin Cancer ☐ Scars ☐ Discolorations

Female:

☐ Hot Flashes ☐ Vaginal Discharge ☐ Nipple Discharge ☐ Menstrual Cramps ☐Premenstrual Depression
☐ Lumps In Breast ☐ Hysterectomy

Male:

☐ Burning On Urination ☐ Difficulty In Starting Urine ☐ Dripping Urination ☐ Prostate Trouble ☐ Prostate Cancer

General:

☐ Recent Weight Gain ☐ Loss Of Sleep ☐ Recent Weight Loss ☐ Loss Of Appetite ☐ General Fatigue
☐ Polio ☐ Rheumatic Fever ☐ Cancer Of Any Kind

If you answered yes to any of the above, please explain:_____

_____

_____ _____

(Your Signature) **(Date)**