Patient Health History Form

Patient Information:

Date: ____/____/____

Name: ____

Address: ____

City: __________________ Zip: _____________ Email: ___________________________

Sex: M/F Age: _______ Date of Birth: ____/____/____

Married: __Widowed: __ Single: __ Minor: __ Separated: __ Divorced: __

Occupation: _________________ Patient Employer/School: ___________________________

Employer/School Address:

____

Employer/School Phone: _________________________

Spouses Name: _______________________ Phone Number: __________________________

Whom may we thank for referring you? ____

Phone Numbers:

Home: __________________________ Cell: ___________________________

Contact in case of an emergency: _________________________ Number: ______________________

Accident Information:

Date of Loss: ____/____/____

Is your current complaint due to an accident? Y/N

Type of accident: Auto: __ Work: __ Home: __ Other: __

Attorney name (if applicable): ____

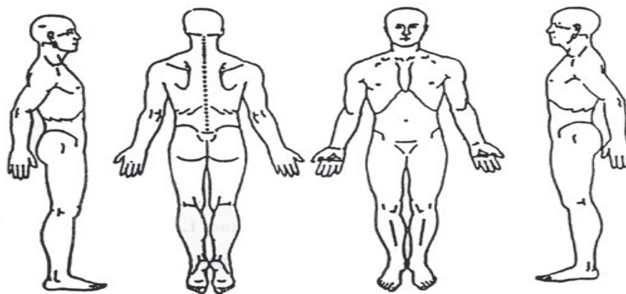
Patient Condition:

Reason for visit: ____

When did your symptoms appear? _________________________________

Is your condition worsening? Y/N

Mark with an X where your pain is:



Type of pain:

Burning: __ Sharp: __ Shooting: __ Dull: __ Achy: __ Throbbing: __ Tingling: __ Cramps: __ Stiffness: __ Swelling: __ Other: __

Is the pain constant or come and go? ___________________________________

How often does the pain occur? ____________________________

Does this interfere with: Work: __ Sleep: __ Daily Routine: __ Recreation: __

Activities of movements that are painful to perform:

Sitting: __ Standing: __ Walking: __ Bending: __ Lying Down: __

Health History

What type of treatment have you already received for this condition? Please Circle.

Medications/Physical Therapy/Surgery/Chiropractic Care/None/Other

Please circle to indicate if you have had any of the following:

AIDS/HIV	Diabetes	Liver Disease
Alcoholism	Emphysema	Measles
Allergy Shots	Epilepsy	Migraines

Anemia	Fractures	Miscarriage
Anorexia	Glaucoma	Mononucleosis
Appendicitis	Goiter	Multiple Sclerosis
Arthritis	Gonorrhea	Osteoporosis
Asthma	Gout	Pacemaker
Bleeding Disorders	Heart Disease	Parkinson's
Breast Lump	Hepatitis	Pinched Nerve
Bronchitis	Hernia	Pneumonia
Bulimia	Herniated Disc	Polio
Cancer	Herpes	Prostate Issues
Cataracts	High Blood Pressure	Prosthesis
Chemical Dependency	High Cholesterol	Psychiatric Care
Chicken Pox	Kidney Disease	RA
Rheumatic Fever	Scarlet Fever	STD's
Stroke	Suicide Attempts	Thyroid Problems
Tonsillitis	Tuberculosis	Tumors/Growths
Typhoid Fever	Ulcers	Vaginal Infections
Whopping Cough	Other ___________________________________	

Exercise:

None: __ Moderate: __ Daily: __ Heavy: __

Work Activity: Sitting: __ Standing: __ Light Labor: __ Heavy Labor: __

Habits: Smoking: __ Alcohol Consumption: per week _____Coffee/Caffeine: cups per day ____

High Stress Level: Reason _______________________________________

Are you pregnant? Y/N

Please list any surgeries or injuries you have had:

____
____
____

Please list all medications:

____
____

Allergies: ____

Vitamins: ____