PATIENT HISTORY

Date of Birth_____ Social Security #____-___-_____
Last Name_____ First Name_____
Status: Minor__ Single__ Married__ Divorced__ Widowed__
Address_____ Apt#_____
City_____ St_____ Zip_____
Phone(H)_____ (W)_____ (C)_____
Spouse's name_____ Phone_____
E-mail_____
Your Occupation_____ Employer_____
Employer Address_____
Insurance_____ Policy #_____
Secondary Insurance_____ Policy #_____
Who referred you to this office?_____
In the event of emergency who should we contact?_____
Phone#_____

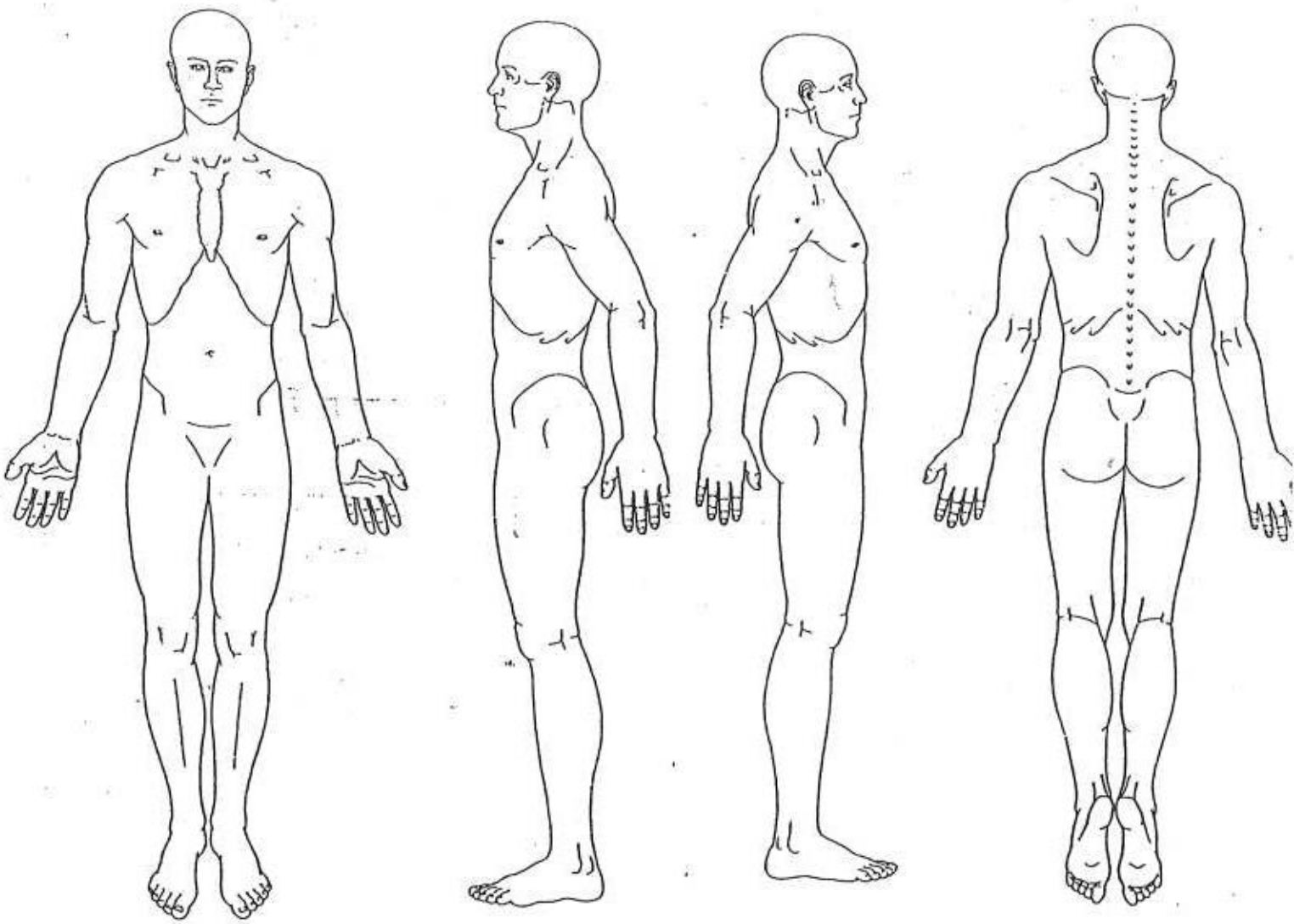
WHAT BRINGS YOU TO OUR OFFICE?

First Complaint: _____

Date when symptom first appeared_____
Work___ Home___ Sports/Play___ Auto___
Did it begin: Gradual___ Sudden___ Progressive over time___
What makes the symptoms increase?_____
What relieves the symptoms?_____
Type of pain: Sharp__ Dull__ Ache__ Burn__ Throb__ Tingling__
Numbness__ Other_____
Does pain radiate into Arm___ Leg___ Does not radiate_____
How often do you experience these symptoms?
100%___75%___50%___25%___10%___Less than 10%___
Is your condition getting worse? __Yes __No __
Is it Constant___ Comes and Goes___
Pain Intensity: ___No pain ___Mild ___Moderate ___Unbearable

PATIENT HISTORY

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	**Where you experience Pain**
NNN	**Where you experience Numbness**
TTT	**Where you experience Tingling**
BBB	**Where you experience Burning**
CCC	**Where you experience Cramping**

PATIENT HISTORY (CONT)

Please list all previous treatments for this condition:

Name of treating physician: _____
Dates of treatment _____
Types of treatment or drugs prescribed _____

Name of treating physician: _____
Dates of treatment _____
Types of treatment or drugs prescribed _____

List all your current health problems:

_____
_____
_____
_____

List any doctors seen for these problems, list treatment and results:

_____
_____
_____
_____

Please list all past surgeries:

Type_____ When_____ Doctor_____
Type_____ When_____ Doctor_____
Type_____ When_____ Doctor_____
Type_____ When_____ Doctor_____

Please list all previous accidents/falls/ injuries (including automobile and work related):

What_____ When_____
What_____ When_____
What_____ When_____

Please list any medications or vitamins you are currently taking:

_____

_____

_____

_____

Any known allergies (medication, vitamins, food, environmental):

_____

_____

_____

Do you smoke? __Yes __No How much? _____
Do you drink coffee? __Yes __No How much? _____
Do you drink tea? __Yes __No How much? _____
Do you drink soft drinks (sodas)? __Yes __No How much? _____
Do you drink water? __Yes __No How much? _____

Family History	**Age**	**Health problems/Cause of Death**
Mother:		
Father:		
Mother's mother:		
Father's mother:		
Mother's father:		
Father's father:		
Brothers:		
Sisters:		
Children:		

Please check the conditions you have or have had:

( ) AIDS OR HIV+
( ) Anemia
( ) Arthritis
( ) Cancer
( ) Epilepsy
( ) Hypoglycemia
( ) Multiple Sclerosis
( ) Parkinson's Disease
( ) Polio
( ) Rheumatic Fever
( ) Tuberculosis
( ) Venereal Disease

CARDIOVASCULAR

( ) General Swelling
( ) Swelling in Legs

( ) Swelling in Face
( ) Swelling around Eyes
( ) Chest Pain
( ) Pounding Heartbeat
( ) Heart "Jumps"
( ) Rapid Heart Beat
( ) Blue or Purple Skin
( ) Blue or Purple Nail Beds
( ) Fainting
( ) Hypertension

( ) Ringing in Ears
( ) Heart Attack
( ) High Blood Pressure

( ) Irregular Heart Beat
( ) Hardening of the Arteries
( ) Areas of Muscle Weakness
( ) Dizziness w/ Nausea
( ) Dizziness w/o Nausea
( ) Blurred Vision
( ) Fainting Spells
( ) Stroke
( ) Diabetes
( ) Pain over the Heart
( ) Cold Hands and Feet
( ) Areas of Numbness
( ) Arthritis of the Neck
( ) Previous neck or Head Injury
( ) Loss of Memory

( ) Inability to form words) talk plainly)
( ) Periods of Blindness in one Eye
( ) Areas of abnormal sensations such as burning
( ) Areas of Numbness
( ) Blood Vessel Disease (Phlebitis, etc,)
( ) Check if You Smoke
( ) Check if your family members have had a stroke
( ) Check if you are taking birth Control Pills

VERTEBROBASILAR

( ) Double Vision
( ) Loss of Coordination
( ) Irregular Muscle Movement

HEAD

( ) Unusually Freq. Headaches
( ) Head Feels Heavy
( ) Vertigo
( ) Lightheadedness
( ) Loss of Smell
( ) Loss of Taste
( ) Loss of Balance
( ) Dizziness

NECK

( ) Pain in Neck
( ) Neck pain w/ movement
( ) Swelling in Neck
( ) Stiff Neck
( ) Pinched Nerve in Neck
( ) Neck feel out of place
( ) Muscle spasms in Neck
( ) Grinding sound in Neck
( ) Popping sound in Neck
( ) Limited Neck Movement

MUSCULAR SKELETAL SYSTEM

( ) Muscle Spasms in Shoulders
( ) Can't Raise Arm
    ( ) Above Shoulder Level
    ( ) Over Head

( ) Low Back Pain
( ) Low Back Feels Out of Place
( ) Muscle Spasms in Low Back

ARMS AND HANDS

( ) Pain in Upper Arm
( ) Pain in Forearm
( ) Pain in Hands
( ) Pain in Fingers
( ) Sensation of Pins & Needles
    ( ) In Arms
    ( ) In Fingers
( ) Fingers go to sleep
( ) Cold Hands
( ) Swollen Joints in Fingers
( ) Sore Joints in Fingers

HIPS, LEGS, & FEET

( ) Pain in Buttocks
( ) Pain down leg
( ) Knee Pain
( ) Leg Cramps
( ) Pins and Needles in Legs
( ) Numbness in Leg
( ) Numbness in Toes
( ) Cold Feet
( ) Swollen Ankles
( ) Swollen Feet

MID BACK

( ) Mid back Pain
( ) Pain between Shoulder Blades

Skin/Hair/Nails

( ) Eczema
( ) Itchy Skin
( ) Dry Scalp
( ) Oily Scalp
( ) Rough, Scaly Skin
( ) Dry Skin
( ) Oily Skin
( ) Psorasis
( ) Yellow Skin
( ) Bruise Easily
( ) Paper thin Nails
( ) Pale Skin
( ) Nail Biting
( ) Baldness

EYES

( ) Blurring of Vision
( ) Double Vision
( ) Eyes Fatigue Easily
( ) Excessive Tearing
( ) Lack of Tearing
( ) Light Bothers Eyes

( ) Dentures
( ) Difficulty Swallowing
( ) Changes in Voice

RESPIRATORY

( ) Shortness of Breath
( ) Can't breathe while lying down
( ) Can't sleep while lying down
( ) Dry Cough
( ) Productive Cough
( ) Cough up Blood
( ) Wheezing

GASTROINTESTINAL

( ) Poor Appetite
( ) Constant Nibbling
( ) Difficulty in Swallowing
( ) Indigestion
( ) Can't East Some Foods
( ) Nausea & Vomiting
( ) Jaundice
( ) Abdominal Pain

Social History

( ) Smoking
( ) Other tobacco use
( ) Alcohol Use
( ) Drink Coffee/ Tea

Diet is ( ) Balanced
( ) Not Balanced

Rest is ( ) Sufficient
( ) Not Sufficient

Recreation is ( ) Sufficient
( )Not Sufficient

My Family Stress is ( ) Severe
( ) Moderate
( ) Minimal
( ) None

How Do You Like Your Job?
( ) I Like It Very Much
( ) It's OK
( ) I Hate It

My Job is ( ) Severe
( ) Moderate
( ) Minimal
( ) None

( ) Nervousness
( ) Irritability
( ) Fatigue
( ) Depression
( ) Generally run down feeling
( ) Crave Sweets
( ) Crave Salt

WOMEN ONLY

( ) Painful Period
( ) Spotting
( ) Vaginal Discharge
( ) Premenstrual symptoms
( ) Irregular Periods
( ) Lumps in Breast

# of Pregnancies _____
# of Deliveries _____

EYES (Continued)

( ) Excessive Itching
( ) Pain in Eyeball

EARS

( ) Loss of Hearing
( ) Pain in Ears
( ) Discharge from Ears
( ) Vertigo
( ) Ringing in Ears

NOSE NASOPHARYNX

( ) Unusual nasal Discharge
( ) Nose Bleeds
( ) Pressure over eyes
( ) Obstruction of Nose
( ) Frequent Colds
( ) Sinusitis
( ) Nasal Allergies
( ) Loss of Sense of Smell
( ) Any Trauma to Nose

MOUTH AND THROAT

( ) Pain in Mouth
( ) Pain in Throat
( ) Bleeding Gums
( ) Cavities

GASTROINTESTINAL

( ) Change In Bowel Habits
( ) Diarrhea
( ) Constipation
( ) Hemorrhoids

GENITOURINARY

Urination is ( ) Frequent
( ) Normal
( ) Infrequent

The Amount is ( ) High
( ) Normal
( ) Low

( ) Need to get up @ night to urinate
( ) Abnormal Intense Desire to Urinate
( ) Difficulty starting urination
( ) Decreased Output
( ) Pain on Urination
( ) Dribbling
( ) Blood in Urine
( ) Cloudy Urine
( ) Lack of Bladder Control
( ) Abdominal Pain

VENEREAL DISEASE

( ) AIDS
( ) Syphilis
( ) Gonorrhea
( ) Other

_____Please do not write below this line_____

Doctor's notes:_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature: _____ **Date:** _____