PATIENT HISTORY

Last _____ First _____ Middle Initial _____ Date of Birth _____

Address _____ City _____ST_____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Email _____ Emergency Contact & Phone _____

Your Occupation _____ Your Employer _____

Typical activities or positions during your day:_____

_____

Who may we thank for referring you to this office?_____

Your #1 Main Problem or Concern

What pain or concern caused you to contact my office? _____

When did this problem start? _____

Did it begin: Gradually Suddenly Progressing over time

How would you describe it? (Check the one that applies) Mild Moderate Severe Intolerable

How often does this the pain occur? (Check box that applies) (Occasional) 0 – 25% 26 – 50% 51 – 75% 76 – 100% (Constant)

Which word or words that best describe your pain. Cramping Aching Dull Sharp Shooting Diffuse Lighting Throbbing Nagging Burning Deep Stinging Pressure

Does this pain travel to other areas outside your spine? Ex: arm(s), leg(s)_____

What makes this feel better? _____

What makes this feel worse? _____

Have you been to anyone else for this problem? Y N Who_____Treatment_____

What else have you done to help this pain? _____

Rate the intensity of your pain on scale of 0-10 (0 being no symptoms, 10 being extreme) Best _____ Worst _____

Do you have another Other Problem or Concern?

Describe your other problem? _____

When did this pain start? _____

Did it begin: Gradually Suddenly Progressing over long time

How would you describe it? (Check the one that applies) Mild Moderate Severe Intolerable

How often does it occur? (Check the one that applies) Daily Weekly Monthly

Which word or words best describe your pain. Cramping Aching Dull Sharp Shooting Diffuse Lightening Throbbing Nagging Burning Deep Stinging Pressure

Does this pain travel to other areas outside your spine, Ex: Arm(s), Leg(s)? _____

What makes this feel better? _____

What makes this feel worse? _____

Have you been to anyone else for this problem? Y N Who_____Treatment_____

What else have you done to treat this pain? _____

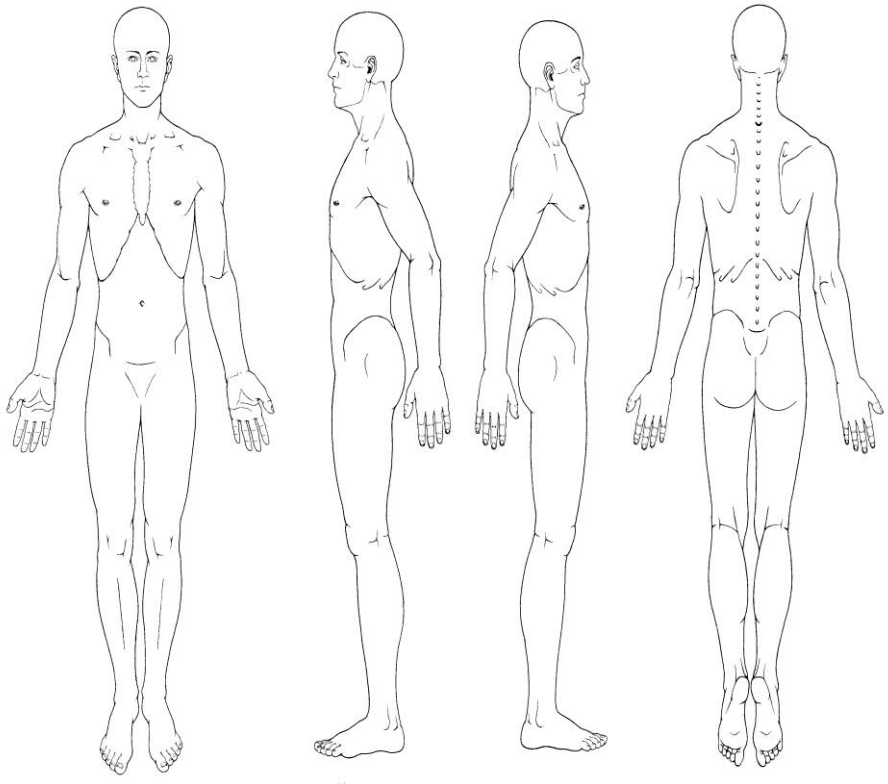
Rate the intensity of the pain on scale of 0-10 (0 being no symptoms, 10 being extreme) Best _____ Worst _____

PATIENT SIGNATURE _____ **DATE** _____

PATIENT HISTORY

Please mark off the areas of concern on the diagram with the following indicators:

PPP = pain
NNN = numbness
TTT= tingling
BBB= burning
CCC= cramping
XXX = other



Physical History

List any broken bones (fractures) or dislocations _____

Ever on crutches? **Y** **N** Why? _____

Ever had spinal tap, epidurals or other spinal injections? **Y** **N** Why? _____

Ever knocked unconscious? **Y** **N** with Lapse in memory? **Y** **N**

Ever worn dental braces? **Y** **N** Any other extensive dental/orthodontic work? **Y** **N**

Ever had x-rays taken? **Y** **N** Why? _____

List any accidents, Injuries, or falls and the dates when occurred _____

_____

Chemical & Social History

Do you exercise? **Y** **N** If yes, how many times per week and what type? _____

_____

Do you have a high stress level? **Y** **N** If yes, list reasons:_____

_____

Are you presently taking any prescription or over-the-counter medication? **Y** **N** Please list, and reason for taking _____

_____

_____

PATIENT SIGNATURE _____ **DATE** _____

PATIENT HISTORY

PAST HISTORY

It is important for me to know of your past history. Please check all that apply to your past medical history.

Please check all of the following that apply to you:

- ☐ Alcohol/Drug Dependence
- ☐ Recent Fever
- ☐ Diabetes
- ☐ Headache
- ☐ Stroke (date) _____
- ☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
- ☐ Taking Birth Control Pills
- ☐ Dizziness/Fainting
- ☐ Numbness in Groin/Buttocks
- ☐ Numbness or pain in (check)arms/legs/hands
- ☐ Loss of sleep
- ☐ Cancer/Tumor (Explain) _____
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ High Blood Pressure
- ☐ Fatigue
- ☐ Abnormal Weight ☐ gain ☐ loss
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Visual Disturbances
- ☐ Osteoporosis
- ☐ Night Sweats
- ☐ Currently Pregnant, # weeks _____

_____

- ☐ Tobacco Use – Type_____ Frequency_____/Day
- ☐ Epilepsy/Seizures
- ☐ Digestive Problems_____

Surgeries_____

Is there any other condition or health factor not previously shared that you wish to discuss? _____

_____

_____

Family History

Has anyone related to you ever been diagnosed with (use key below)

M - Mother F - Father S - Sibling

___ Heart Problems/Stroke ___ Bone Disease (such as Rheumatoid Arthritis) ___ Cancer

___ Auto-immune disorder ___ Diabetes

PATIENT SIGNATURE _____ **DATE** _____