

PATIENT HISTORY FORM

Welcome to the office. Our goal is to help you to the best of our ability. This requires that we learn about your illness and about how you came to visit us. The questions below will help us to not overlook any important information. Please answer them briefly. Some of them may not apply to you, and answer them as N/A. If you cannot remember specific dates, the month or approximate year will be helpful. If you cannot recall a requested name or place, draw a line through the space to greatly help us give you the best possible care.

NAME _____ AGE _____ Male Female BIRTH DATE ____/____/____
Home address: _____ Apt or Suite # _____
City _____ State _____ Zip _____ Home Phone: _____
OCCUPATION _____ Work Phone: _____
 HEIGHT _____ WEIGHT _____ SS#: ____/____/____ Driver's License # _____
How were you referred to our office? Insurance Co. Qwest DEX Yellow Book Health Fair Walk-in Flyer/Handout Internet/Web Page Patient Referral Name: _____
Employer _____ In the event of an emergency who should we contact: _____
Relation: _____ Home Phone: _____ Work Phone: _____
(WOMEN) are you or could you be pregnant: YES NO

Identify the **method of payment**. Check one of the following:
Cash _____ Group Insurance _____ Auto Insurance _____ Workers Comp Ins. _____
Insurance Information: (SKIP IF YOU ARE PAYING BY CASH)
If you are the primary insured on the plan please write self.
Insured's Name: _____ Relation: _____
Insured's Employer: _____ Insured's SS#: ____/____/____ Policy # _____ Group #: _____
Insured's Birthdate _____ CLAIM # _____ If auto or work comp. Related.

CHIEF COMPLAINTS/MAIN PROBLEMS (List most severe first)

1. _____
2. _____
3. _____
4. _____
5. _____

Date these problems began _____ Are you still working? Yes _____ No _____ Last day on the job. _____
Did your problems begin following:
 A fall Lifting Twisting Bending Over Work Injury Motorized Vehicle Accident Recreational injury Sports Event Injury No apparent cause Other: _____
Describe all the details of any accident, incident or the way these problems began. _____

Where is the location of your pain today? _____
Is your pain today _____ worse _____ better _____ the same compared to when it began?
What reduces the pain?
_____ Lying down _____ Manipulation _____ Muscle Relaxant Pills _____ Injections for pain
_____ Sitting _____ Home exercises _____ Aspirin Anti-inflammatory Pills _____ Walking
_____ Standing _____ Pain pills _____ Exercises in physical therapy _____ Massage
_____ Nothing _____ Other _____

What activities make it worse?
_____ Exercises (during) _____ Standing _____ Bending backward _____ Driving
_____ Exercises (after) _____ Walking _____ Coughing _____ Lying down
_____ Sitting _____ Bending forward _____ Sneezing _____ Changing position
What is the time interval between attacks of pain? Constantly Daily Weekly Monthly Yearly
Have you been constant in pain since it began or is your pain intermittent? Describe _____

Does your pain intensity vary throughout a 24 hour period? YES NO
Have you noticed any: Numbness Tingling Sensitivity with your pain? Can you climb or descend stairs? YES NO
Has your pain affected your sex life? YES NO Do your arms/legs get weak with your pain? YES NO
What position do you have to be in at rest? Stand Sit Lying Down Do you have full control of your bladder and bowels? YES NO

Choose the number which best answers the question:
0 2 4 6 8 10
NONE MILD DISCOMFORTING DISTRESSING HORRIBLE EXCRUCIATING
_____ Your pain right now _____ Your pain at it's worst _____ The worst stomachache you ever had
_____ Your pain at least _____ The worst toothache you ever had _____ The worst headache you ever had

Is your pain and disability so severe that you would consider surgery for some relief? YES NO
Have you been hospitalized for your pain problem? YES _____ NO _____ Number of times _____ Dates _____

Please check what treatments you have had for your condition.

	<input checked="" type="checkbox"/>	DATE STARTED	DATE STOPPED
1. Chiropractic.....	<input type="checkbox"/>	_____	_____
2. Acupuncture.....	<input type="checkbox"/>	_____	_____
3. Physical Therapy.....	<input type="checkbox"/>	_____	_____
4. Home Stretching Exercises..	<input type="checkbox"/>	_____	_____
5. Hm Strengthening Exercises	<input type="checkbox"/>	_____	_____
6. Epidural Block.....	<input type="checkbox"/>	_____	_____
7. Facet Block.....	<input type="checkbox"/>	_____	_____
8. Neurological Consult.....	<input type="checkbox"/>	_____	_____
9. Orthopedic Consult.....	<input type="checkbox"/>	_____	_____
10. Pain Medication.....	<input type="checkbox"/>	_____	_____
11. Massage Therapy.....	<input type="checkbox"/>	_____	_____

Have you had any of these diagnostic studies?

	YES	NO
Diagnostic X-rays.....	<input type="checkbox"/>	<input type="checkbox"/>
CT (computer tomography) Scan.....	<input type="checkbox"/>	<input type="checkbox"/>
Myelogram (x-ray with dye injection)..	<input type="checkbox"/>	<input type="checkbox"/>
Electromyogram (EMG).....	<input type="checkbox"/>	<input type="checkbox"/>
Nerve Conduction Velocity (NCV).....	<input type="checkbox"/>	<input type="checkbox"/>
Discogram.....	<input type="checkbox"/>	<input type="checkbox"/>
MRI (Magnetic Resonance Imaging)...	<input type="checkbox"/>	<input type="checkbox"/>
Arthrogram or Sonogram.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood work.....	<input type="checkbox"/>	<input type="checkbox"/>
DEXA Bone Scan.....	<input type="checkbox"/>	<input type="checkbox"/>

PAST MEDICAL HISTORY

Circle if you currently have, or previously suffered from:

Arthritis.....	Yes	No	When _____	Psoriasis.....	Yes	No	When _____
Asthma.....	Yes	No	When _____	Psychiatric or Emotional..	Yes	No	When _____
Cancer.....	Yes	No	When _____	Rheumatic Fever.....	Yes	No	When _____
Diabetes.....	Yes	No	When _____	STD's.....	Yes	No	When _____
Emphysema.....	Yes	No	When _____	Stroke.....	Yes	No	When _____
Gastritis.....	Yes	No	When _____	Thyroid Disorders.....	Yes	No	When _____
Glaucoma.....	Yes	No	When _____	Transient Ischemic Attack	Yes	No	When _____
Heart Disease.....	Yes	No	When _____	Tuberculosis.....	Yes	No	When _____
HIV+/AIDS.....	Yes	No	When _____	Ulcers.....	Yes	No	When _____
Liver Conditions.....	Yes	No	When _____	High/Low Blood Pressure.	Yes	No	When _____
Migraines.....	Yes	No	When _____	Seizures / Epilepsy.....	Yes	No	When _____
Osteoporosis.....	Yes	No	When _____	Other: _____			
Polio.....	Yes	No	When _____				

Are you currently taking any medications? YES NO

If yes, please list including dosage and times per day.

_____	Number/Each Day _____	_____	Number/Each Day _____
_____	Number/Each Day _____	_____	Number/Each Day _____
_____	Number/Each Day _____	_____	Number/Each Day _____

(Women) Are you or were you taking birth control? Yes _____ No _____ When _____ For How Long _____

Who is your current primary care doctor? Name: _____ Location: _____

Do we have your permission to Consult your PCP if needed in your case? YES NO sign your name: _____

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

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

REVIEW OF SYSTEMS

PLEASE write in any medical problems not previously mentioned in the spaces provided.

Cardiovascular System: _____
Neurological System: _____
Gastrointestinal System: _____
Respiratory System: _____
Genitourinary System: _____
Musculoskeletal System: _____
Psychiatric or Emotional: _____

SOCIAL HISTORY

Number of children _____ Ages _____ Number living at home _____ Martial Status: S M W D

Education level achieved: Grade school Jr. High High school College Post Grad.

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 _____