

# 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 \_\_\_\_\_