HEALTH HISTORY

PLEASE COMPLETE FORM BELOW

NURSE USE ONLY:
Physical Examination: HT: _____ WT: _____ B/P: _____
T: _____ P: _____ R: _____

HEENT: _____
Neck: _____
Chest/Lungs: _____
Heart: _____
Abd: _____

Name: _____ Today's Date: _____

DOB: _____ Age: _____

Name of your primary care physician: _____

For what problem are you seeing the doctor today? _____ Who referred you? _____

When did this problem start? _____

How did the pain start? Gradually_____ Suddenly_____ Lifting_____ Fall_____ Bending_____ Pulling_____
Injured in auto accident_____ Injured at work_____ Injured during sports_____
No apparent cause_____ Other_____

What activities make the pain worse? Sitting_____ Standing_____ Walking_____ Lifting_____
Getting up from seated position_____ Bending forward_____ bending backward_____
Coughing_____ Sneezing_____

What Reduces the pain? Lying down_____ Sitting_____ Walking_____ Changing positions_____
Physical therapy_____ Medicines_____ Chiropractic manipulations_____ Injections_____
Nothing_____ Other_____

Have you ever had pain like this before? No_____ Yes_____ When? _____

On a scale of 0 – 10, 0 being no pain and 10 being the worst pain you can imagine, how bad is your pain right now? _____

On a scale of 0 – 10, how bad is your worst pain since the problem started? _____

Are you having difficulty with coordination? YES or NO With balance? YES or NO

Are you having difficulty with Bladder or Bowel Control? YES or NO

How has this problem been treated up to now? Local heat or ice_____ Non-Prescription medicine_____ Prescription medicine_____
Phyiscal therapy_____ Chiropractic manipulation_____ Massage_____ Acupuncture_____ Other_____

Have you had surgery for this problem? No _____ Yes _____
Where and when was surgery done? _____
Name of surgeon _____
What type of surgery was this? _____

What other health care providers have you seen for this problem?
_____

Are you receiving any compensation for this problem? No_____ Yes_____
Workers Compensation? _____ Other_____

Are you involved in any legal proceedings for this problem, or do you anticipate legal action because of this problem? No_____ Yes_____

Please list all medical problems you have now or that you have had in the past. High blood pressure_____ Asthma_____
Heart problems_____ Pacemaker_____ Diabetes_____ Cancer_____ Epilepsy(seizures)_____
Easy Bleeding_____ Blood Clots_____ Malignant Hyperthermia_____

Other Medical Problems: _____
_____
_____

Please list all surgeries you have ever had, with the approximate date it was performed.
_____
_____
_____

Please list all medications you currently take / dose / times per day

_____
_____
_____
_____
_____
_____

Do you take aspirin? _____

Please list any medication allergies / reactions

_____
_____
_____
_____

Please list your occupation _____

Please list last grade completed in school _____

Do you use tobacco? No _____ Yes _____ Smoke? _____ How much? _____ Chew? _____

Do you drink alcoholic beverages? No _____ Yes _____ How much? _____

Have you ever had a problem with abuse of alcohol, prescription drugs, or recreational drugs? No _____ Yes _____

Explain:_____

Have you ever been diagnosed with a mental health problem? No _____ Yes _____

Depression _____ Anxiety _____ Bipolar Disorder _____ Borderline personality _____

Obsessive Compulsive_____ Schizophrenia _____ Other _____

If yes, how has this been treated? _____

_____

Have any of your immediate blood relatives had any of the following problems? Diabetes _____ Heart Disease _____

Heart Attack _____ Seizures _____ Reactions to anesthesia _____ High Blood Pressure _____ Cancer _____

Easy Bleeding _____ Blood Clots _____ Malignant Hyperthermia _____ Other _____

Have you recently experienced any of the following symptoms? Fevers _____ Shaking Chills _____ Night Sweats _____

Unexplained Weight Loss _____ Loss of Bowel or Bladder Control _____ Weakness in Arms or Legs _____

Chest Pain _____ Shortness of Breath _____ Waking up at Night unable to Breathe _____ Blood in Stool _____

Double Vision or Loss of Vision _____ Passing Out or Almost Passing Out _____ Coughing Up Blood _____

Difficulty Swallowing or Speaking _____

Explain _____

_____