PATIENT HEALTH HISTORY

Name: _____ Today's Date _____

Height: _____ Weight: _____ BP: _____

INSTRUCTIONS Please FILL-IN or CIRCLE all responses. If you have questions, please ask a staff member for assistance.

1. **Chief Complaint** (What problem(s) or condition(s) would you like us to examine?)

_____

_____

2. Please explain **how** the injury started. Unknown No Injury Old Injury Slip or Fall Overexertion Repetitive Use Slept Wrong
   Other (Explain) _____

3. **When** did your symptoms start? _____ What were you doing? _____

4. Have the symptoms ever occurred before? Yes No If Yes, when and how often? _____

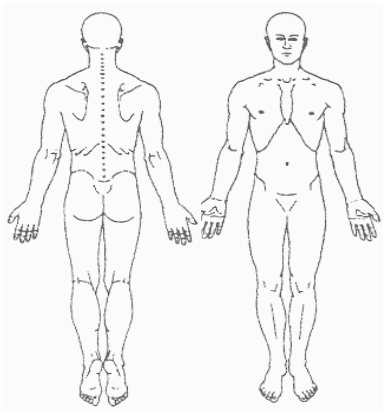
5. How would you **describe** your current symptoms? Sharp/Shooting Pain Radiating Pain Localized Pain Diffuse Pain Dull Ache
   Numbness/Tingling Stiffness Weakness Burning Throbbing
   Other (Explain) _____

6. Rate your **level of PAIN**. (0=No Pain, 10=Severe Pain) 0---1---2---3---4---5---6---7---8---9---10

7. Rate how you pain **interferes** with Activity. (0=No Pain, 10=Severe Pain) 0—1---2---3---4---5---6---7---8---9---10

8. How **often** do you have these symptoms? _____ % of the day

9. **Please mark the area of your symptoms on the diagram to the right**.



10. Is your condition? Worsening Improving Unchanging Constant Comes and Goes

11. **When** is your condition **worse**? Morning Afternoon Night With Activity

12. Do your symptoms seem to be **better with**? Nothing Stretching Cold Heat
    Rx Medications Massage Movement Walking Standing Sitting Rest
    OTC Medications Exercise Chiropractic Bending Activity
    .

13. Circle any of the following **signs or symptoms** that are associated with your current condition.

Joint Stiffness	Restricted Motion	Muscle Spasm	Redness	Deformity
Headaches	Loss of Coordination	Weakness	Cold Limb	Heat
Radiating Pain	Abnormal Sensation	Swelling	Nausea	Fatigue
Body Ache	Numbness /Tingling	Dizziness	Vomiting	

PAST HEALTH HISTORY

14. Please list any **other doctors or providers** that you have seen for your condition(s). _____

_____

15. What **treatment** have you already received for your condition(s). Medications Surgery Physical Therapy Chiropractic None Other

_____

16. Date of Last: Physical Exam _____ Spinal X-Ray _____ MRI _____ CT Scan _____
Bone Scan _____ Blood Test _____ Other _____

17. **Past/Present Illnesses**. (Please circle)

AIDS/HIV Alcoholism Anemia Anorexia Arthritis Asthma Bleeding Disorders Bronchitis
Bulimia Cancer Chemical Dependency Diabetes Emphysema Epilepsy Gout Heart Disease Hepatitis
High Cholesterol Kidney Disease Liver Disease Migraine Headaches Multiple Sclerosis Osteoporosis
Parkinson's Disease Rheumatoid arthritis Stroke Ulcers Venereal Disease Other _____

18. **Surgeries**. (Please list all surgical procedures that have had in the past and approximate date.)

_____

19. **Injuries**. (Please list any significant injuries, falls, head injuries, broken bones, dislocations, trauma that you have had in the past.)

_____

20. **Medications**: _____

Allergies: _____

Vitamins/Herbs/Minerals: _____

21. **Are you pregnant?**: ___ Yes ___ No Due Date _____

FAMILY HISTORY

22. Please complete the chart below indicating as much information as you know about your family. (Cancer, Heart Disease, Diabetes, etc.)

General Family	Health Conditions		Health Conditions
Father	_____	Son(s)	_____
Mother	_____	Daughter(s)	_____
Brother(s)	_____	Sister(s)	_____
Paternal Grandfather	_____	Maternal Grandfather	_____
Paternal Grandmother	_____	Maternal Grandmother	_____

SOCIAL HISTORY (PLEASE CHECK AND FILL IN ALL RESPONSES)

23. **EXERCISE**	**WORK ACTIVITY**	**HABITS**	
____ NONE	____ SITTING	____ SMOKING	PACKS/DAY _____
____ MODERATE	____ STANDING	____ ALCOHOL	DRINKS/WEEK _____
____ DAILY	____ LIGHT LABOR	____ COFFEE/CAFFEINE DRINKS	CUPS/DAY _____
____ HEAVY	____ HEAVY LABOR	____ HIGH STRESS LEVEL	REASON _____

24. Please describe your **diet**:

VEGETABLES	SERVINGS/DAY _____	MEAT/FISH	SERVINGS/WEEK _____
FRUIT	SERVINGS/DAY _____	MILK/CHEESE	SERVINGS/WEEK _____
NUTS	SERVINGS/DAY _____	SUGAR/CHOCOLATE	SERVINGS/WEEK _____
BREAD/PASTA	SERVINGS/DAY _____	FAST FOOD	SERVINGS/WEEK _____

How much **water** do you drink per day? _____ ounces

25. Please rate (by circling) the following. 0=Not Affected, 1=Annoying, 2=Painful but Not Limited, 3=Difficult to Perform, 4=Unable to Perform

Household Chores:	0---1---2---3---4	Sexual Activities:	0---1---2---3---4	Shaving:	0---1---2---3---4	Exercise:	0---1---2---3---4
Climbing Stairs:	0---1---2---3---4	Sleeping:	0---1---2---3---4	Dressing:	0---1---2---3---4	Work Tasks:	0---1---2---3---4
Looking Up:	0---1---2---3---4	Sitting:	0---1---2---3---4	Lifting:	0---1---2---3---4	Yard Work:	0---1---2---3---4
Looking Down:	0---1---2---3---4	Standing:	0---1---2---3---4	Driving:	0---1---2---3---4	Recreation:	0---1---2---3---4
Carrying Groceries:	0---1---2---3---4	Daily Pet Care:	0---1---2---3---4	Bending:	0---1---2---3---4	Gripping:	0---1---2---3---4
Change Positions:	0---1---2---3---4	Kneeling:	0---1---2---3---4	Walking:	0---1---2---3---4	Computer Use:	0---1---2---3---4

26. Is there anything else you would like to discuss today? _____

27. REVIEW OF SYSTEMS
Please circle any of the conditions below that you have had in the past 1 year or are currently experiencing.

Constitutional
Fever
Chills
Drowsiness
Fatigue
Night Sweats
Weight Gain
Weight Loss

Eyes
Blurring
Double Vision
Light Sensitivity
Eye Pain
Change in Vision
Eye Trauma
Itching
Tearing
Wears Glasses

Ears, Nose & Throat
Hearing Loss
Ear Pain
Ear Discharge
Ear Ringing
Dizziness
Loss of Smell
Frequent Colds
Nasal Congestion
Nose bleeds
Post Nasal Drip
Sinus Pain/Infections
Hoarseness
Sore Throats
Bleeding Gums
Tooth Extraction
Altered Taste
Abscess

Respiratory
Shortness of Breath
Wheezing
Cough
Coughing up blood
Sputum Production

Cardiovascular
Chest Pain
Leg Swelling
Leg Pain/Aching
Heart Murmur
Heart Palpitations
Ulcers
Varicose Veins

Gastrointestinal
Apetite Loss
Difficulty Swallowing
Heartburn
Nausea
Vomiting Blood
Rectal Bleeding
Constipation
Diarrhea
Abdominal Pain
Belching
Black, Tarry Stools
Thin Stools
Hemorrhoids
Indigestion
Yellow Skin
Excessive Gas

Female
Birth Control Therapy
Breast Lumps/Pain
Burning Urination
Cramps
Frequent Urination
Hormone Therapy
Irregular Menstruation
Painful Menses
Urine Retention
Vaginal Bleeding
Vaginal Discharge
Miscarriage(s)
Difficult Pregnancy

Male
Burning Urination
Erectile Dysfunction
Frequent Urination
Hesitancy or Dribbling
Prostate Problems
Urine Retention

Endocrine
Goiter
Cold Intolerance
Heat Intolerance
Diabetes
Excessive Appetite
Excessive Thirst
Frequent Urination
Hair Loss
Unusual Hair Growth
Voice Changes

Skin
Rash or Hives
Nail Texture Change
Skin Color Change
Hair Growth
Hair Loss
Excessive Sweating
Skin Lesions or Ulcers

Nervous System
Seizures or Tremors
Dizziness
Facial Weakness
Headaches
Limb Weakness
Loss of Consciousness
Loss of Memory
Numbness
Slurred Speech
Unsteadiness of Gait

Psychological
Depression
Mood Changes
Confusion
Anxiety/Nervousness
Irritability
Appetite Changes
Suicidal Thoughts
Sleep Disturbance

Hematology/Lymph
Anemia
Blood Clotting Problems
Blood Transfusion(s)
Bruises easily
Lymph Node Swelling
Lymph Node Tenderness

GU
Pain in the Side
Pain in the Groin
Urinary Urgency
Urinating at Night
Blood in Urine
Urinary Hesitancy
STD
Urinary Itching
Prior Kidney Stones