



PATIENT HISTORY FORM

Patient: PLEASE PRINT

First Name M.I. Last
How did you hear about us?
Gender: M F Birthdate Age:
Are you: Single Married Divorced Widowed Separated
Home Address Apt #
City State Zip
Home Phone Pager/Cell Phone
Work Phone Ext.
E-mail Address
Occupation
Name of Insured (if different from name above) D.O.B.
Employer Name

My Account Will Be Handled By:

- Self Pay Health Insurance Work Comp. Personal Injury

Symptoms

Primary Complaint
When did it start?
Is this problem caused by an accident, injury, or fall? YES NO
Type of Injury: Auto Work Home Other
Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain)
Is this condition getting progressively worse? Yes No
Is the pain constant? Yes No
Activities or movements that are difficult to perform:
Sitting Standing Walking Bending Lying Down Other
What treatment have you already received for this condition? Medications Physical Therapy Surgery Chiropractic None Other

Other Symptoms

- Headaches Pins & Needles in Legs Loss of Smell
Neck Pain Pins & Needles in Arms Loss of Taste
Upper Back Pain Numbness in Fingers Diarrhea / Constipation
Mid Back Pain Numbness in Toes Low Back Pain
Difficulty Breathing Hip Pain Fatigue Stomach Upset
Leg Pain Depression Loss of Balance Shoulder Pain
Ears Ringing / Buzzing Loss of Memory Chest Pain
Light Bothers Eyes Irritability Dizziness Nervousness



Daily Habits

Exercise: None Moderate Daily Heavy
Work Habits: Sitting Standing Light labor Heavy labor
Sleep Position: Side Stomach Back
Do You Smoke? Yes No Packs/ Day _____
Do You Drink Alcohol? Yes No Drinks/ Week _____
Coffee/ Caffeine Drinks? Yes No Cups/ Day _____
Do You Have High Stress? Yes No Reason _____

What Vitamins/Nutritional Supplements do you take?

What Medications are you taking?

Health History

Injuries/Surgeries you have had Description and Date

Falls _____
Head Injuries _____
Broken Bones _____
Dislocations _____
Surgeries _____
Auto Accidents _____
Hospitalizations _____

Women

Are you Pregnant? Yes No
Taking Birth Control? Yes No
Are you currently on any hormone replacement therapy? Yes No

My Health Attitude- Please mark which one applies to you

- Treatment Only-** I only consult a doctor when I have an ache or a pain and discontinue as soon as it is cleared up.
- Prevention-** In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring.
- Maintaining Health-** I'm conscious about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential.
- Family Health-** I take an active part in assisting, informing, and maintaining health, with my family. I'm concerned with the long-term affects of good health.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature _____ **Date** _____