PATIENT HISTORY

NAME:____________________________________AGE_______Current Height (in inches) ______ Current Weight (in lbs) _____________

Race:_____________________ Ethnicity:__________________________

Primary Care Physician:__________________________________ Referring Physician: ____

Reason for visit:____ Date when the current problem started __________________________

The current problem is a result of a(n): Check all that apply: ☐Car Accident ☐Work Accident ☐Other

Other providers seen for this current episode of symptoms? ____

Prior testing or treatment of the problem ***IN THE PAST YEAR ONLY***. Check all that apply: ☐MRI ☐Xrays ☐CT Scan ☐EMG

If treated with **Physical Therapy** (PT) what date did you start? ______ Total visits of physical therapy in the last 12 months_____________

Have you had any treatments with the **Chiropractor** in the last 6 months? ☐yes ☐ no Date of 1st chiropractic treatment? ____________

How many treatments? _______

Have you had any of the following **Injections** in the last 6 months? ☐ Epidural Injections ☐ Facet Injections ☐ Trigger Point Injections

How many sessions of injections did you receive in the last 6 months? ________When did injection treatment start? _________________

What has this episode impacted? ☐Sleep ☐ Exercise ☐Work ☐Driving

Current level of pain on scale of 0-10 __________________ Worse level of pain with this flare up on scale of 0-10? __________________

MEDICAL HISTORY: ***Check*** *and/or* ***Circle all that apply***: Recent physical? Yes / No How long ago? _______________________

☐ Heart Attack
☐ Angina
☐ Bypass or ☐ Angioplasty
☐ Heart Valve Disease
☐ Mitral Valve Prolapse (MVP) ☐ Other Heart Condition *explain
☐ Pacemaker
☐ High Blood Pressure
☐ High Cholesterol
☐ Diabetes-☐ Insulin dependent?

☐ Kidney or Renal Disease
☐ Urinary Disorder *explain
☐ Liver Disease
☐ Hepatitis
☐ Blood Transfusion
☐ HIV / AIDS
☐ Other Immune Disorder
☐ Asthma
☐ Lung Disease *explain
☐ Stroke (CVA) or ☐ TIA

☐ Thyroid Disease
☐ DVT or Phlebitis
☐ Anemia
☐ Bleeding /Blood Disorder
☐ Ulcers
☐ Bowel Disorder *explain
☐ Breast Disease
☐ Rheumatoid Arthritis
☐ Cancer *explain
☐ History of MRSA

☐ Diagnosed Migraines
☐ Headaches (not occasional ones)
☐ Seizure
☐ Memory Problems
☐ Difficulty with Speech
☐ Nausea or Vomiting
☐ Double vision ☐ Blurred Vision
☐ Fibromyalgia
☐ Depression
☐ Other *explain

***** *Explanation of any* ***starred*** ____

LIST ALL PRIOR SURGERIES	YEAR

LIST ALL MEDICATION, incl. non-prescription

ALLERGIES TO MEDICATIONS:
☐ **Latex Allergy** ☐ NONE KNOWN ☐ YES, LIST ALL:

Have you ever had problems with anesthesia or complications following any surgery? ☐ No ☐ Yes If yes, please explain: ____

SOCIAL HISTORY: **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation:______________________________ **Sports/Activities:** _____________________________________

Do you live alone? ☐ Yes ☐ No **Do you have children @ home?** ☐ Yes ☐ No Age(s): ___________

Do you smoke?
☐ No, I have never smoked.
☐ No, I quit _______ years ago
☐ Yes, I smoke_________ packs per day for the past ____________ years.
☐ Cigars ______ per week ______ per month
☐ **History of substance abuse**, explain: ________________________________

Do you drink alcohol?
☐ No, never ☐ Rarely ☐ Socially
☐ 1 or more times a month
☐ 1 or more times a week
☐ Daily Explain: _______________

The above information is accurate to the best of my knowledge. I understand that this information, including alcohol/substance use and HIV/AIDS information is part of my medical chart and may be released as such upon authorized request.

SIGNATURE:____ DATE: ________/________/