PATIENT HISTORY

Name: _____ Date: _____
Address: _____ Age: _____ Birthdate: _____
Phone: (home) _____ (cell) _____ (work) _____
e-mail: _____ Sex: M F Marital Status: M S W D Separated
Employer: _____ Name of Spouse: _____
Employer Address: _____ Spouse Employer: _____
Occupation: _____ Spouse Employer Address: _____
Emergency Contact/Phone: _____
Who were you referred by so we may thank them? _____

Main Complaint:

What is the main reason for you being seen today? _____

_____

How long has this bothered you? _____
Do you know what caused it? Please describe onset or accident as best as possible. _____

_____

Is the pain localized to one area? If yes, where? _____
Does the pain move? Please describe. _____
What aggravates or makes your condition worse? _____

_____

Does anything relieve it? If yes, what? _____
Have you seen any other Doctors for this condition? If yes, who? _____
Have you missed any work because of this problem? (dates) _____

Past History:

List any previous significant injuries. Give dates if possible. _____
List any significant illnesses (diabetes, heart disease, high blood pressure, etc.) _____
Are you taking any medications, including over the counter or vitamins? Please list: _____

_____

Please list any allergies: _____
Do you use Alcohol, tobacco or recreational drugs? If yes, please list: _____

_____

Do any diseases run in your family? (Diabetes, cancer, high blood pressure, etc.) Please list and name who has disease: _____

_____

Are you under any doctors' care? If yes, for what? _____

_____

To the best of my knowledge, all statements on this form are true and answered to the best of my ability.

Signature of patient or parent if minor: _____

Date: _____

PATIENT HISTORY

PLEASE MARK THE AREAS OF YOUR BODY WHERE YOU HAVE HAD SYMPTOMS SINCE YOUR PAIN STARTED. USE SYMBOLS BELOW.

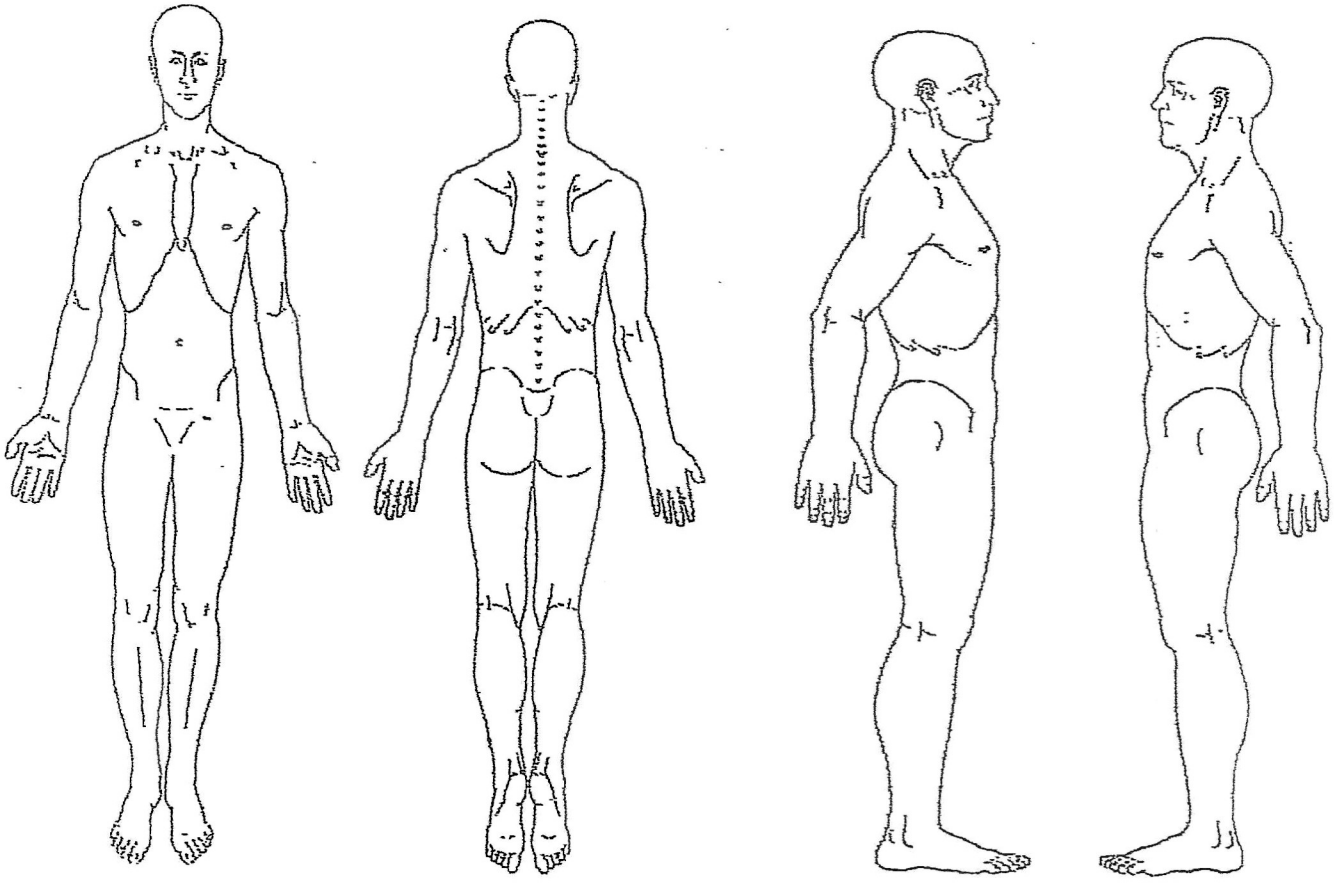
Main Pain *

Burning X

Stabbing ^^^

Numbness ////////

Pins and needles ::::::::



FRONT BACK RIGHT LEFT

PUT A CIRCLE AROUND THE AREAS THAT HURT RIGHT NOW.

USE THE FOLLOWING PAIN SCALE TO GRADE THE INTENSITY OF YOUR PAIN.

Circle the number to indicate your pain at the onset

none 0 1 2 3 4 5 6 7 8 9 10 unbearable
mild moderate severe

Circle the number to indicate your pain now

none 0 1 2 3 4 5 6 7 8 9 10 unbearable
mild moderate severe