Patient Medical History

The following information is needed in order to better serve you. If you need additional room, use the back of this sheet. If you need any assistance, please do not hesitate to ask office staff.

Please print!

Briefly describe what brought you into our office: _____

_____

_____

How did this injury/exacerbation occur?: _____

_____

My pain is worse (circle): in the morning / during the day / at night / constantly / with activity / during rest

On a scale from 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)

Please rate your pain at its best _____ and at its worst _____

Have you been hospitalized for your present condition? **Yes / No** If yes, date: / /

Have you had surgery for your present condition? **Yes / No** If yes, date: / /

If yes, surgery type (if more than one operation, please list): _____

_____

Have you had any falls in the past 12 months? **Yes / No** If yes, how many? _____

Have you received previous treatment for this condition? **Yes / No** If yes, date: / /

If yes, please summarize: _____

_____

Have you ever had any of the following? (please circle): EMG CT Scan Myelogram MRI X-Ray

Are you taking any medications? Please list (you may use reverse side): _____

_____

Patient Medical History

Please check all that apply:

Allergies

- ☐ Animals
- ☐ Eggs
- ☐ Rubber
- ☐ Alpha Drugs
- ☐ Dairy
- ☐ Dust
- ☐ Chocolate
- ☐ Mold
- ☐ Aspirin/Pain Medication
- ☐ Latex
- ☐ Seasonal Allergies
- ☐ Flu Shot
- ☐ Codeine
- ☐ Penicillin
- ☐ Pollen
- ☐ Bee Sting
- ☐ Lergia
- ☐ Shellfish
- ☐ Tetracycline
- ☐ Wheat
- ☐ X-Ray Dye
- ☐ Soaps
- ☐ Lavender

Other: _____

_____

General Medical History

- ☐ Ankle Pain
- ☐ Back Pain
- ☐ Depression
- ☐ Epilepsy
- ☐ Foot Pain
- ☐ Hearing Problems
- ☐ Jaw pain
- ☐ Low Back Pain
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Significant Weight Change
- ☐ Stomach Problems
- ☐ Vertigo
- ☐ Hypothyroid
- ☐ Fatigue
- ☐ Arm Pain
- ☐ Broken Bones
- ☐ Diabetes
- ☐ Eye/Vision Problems
- ☐ Genetic Spinal Disorder
- ☐ Hepatitis
- ☐ Joint Stiffness
- ☐ Menstrual Problems
- ☐ Neck Pain
- ☐ Polio
- ☐ Spinal Cord Injury
- ☐ Tumor
- ☐ Upper Back Pain
- ☐ Arthritis
- ☐ Cancer
- ☐ Dizziness
- ☐ Fainting
- ☐ Hand Pain
- ☐ High Blood Pressure
- ☐ Knee Pain
- ☐ Mid Back Pain
- ☐ Neurological Disorder
- ☐ Prostate Problems
- ☐ Neuropathy
- ☐ Osteoarthritis
- ☐ Hyperthyroid
- ☐ Sprain/Strain
- ☐ Tinnitus
- ☐ Brain Fog
- ☐ Asthma
- ☐ Chest Pain
- ☐ Elbow Pain
- ☐ Headaches
- ☐ Hip Pain
- ☐ Leg Pain
- ☐ Minor Heart Trouble
- ☐ Pacemaker
- ☐ Shoulder Pain
- ☐ Wrist Pain
- ☐ Sciatica
- ☐ Disc Herniation

Other: _____

_____

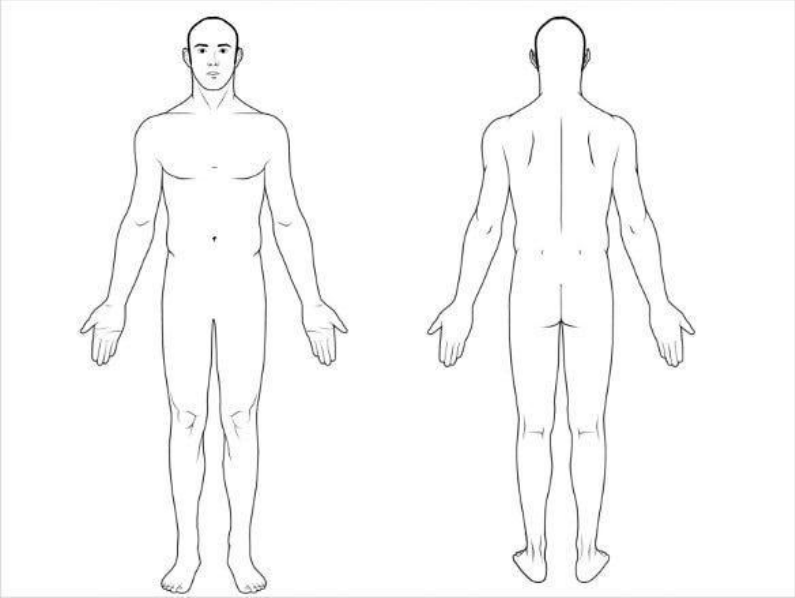
Patient Medical History

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition:

Key:

1. ↑ or ↓ Radiating Pain
2. //// Numbness/Tingling
3. XXX Spasm
4. 000 Ache/Pain
5. ZZZ Tenderness



Is there any other information regarding your medical history that we should know about?

_____

_____

_____

_____

_____

What is your goal for treatment at this time? _____

_____

Patient's Name (Printed):_____

Patient/Guardian Signature:_____

Office Staff Signature:_____ Date: / /