**PATIENT HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **LAST NAME** | **FIRST** | **DATE OF BIRTH** | **SOCIAL SECURTIY NUMBER** | **PRONOUNS** ** HE/HIM  SHE/HER**** THEY/THEM  DECLINE** |
| **ADDRESS** | **CITY** | **STATE** | **ZIP CODE** |
| **EMAIL**  | **PHONE** | **How would you like to receive appointment****reminders?** | ** PHONE**** TEXT**  |

**EMERGENCY CONTACT & RELATION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PHONE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us?**  Social Media  Doctor Referral  Google  Friend/Family  Neighborhood

|  |  |  |
| --- | --- | --- |
| First Name:  | Last Name: | Phone #:  |

**Referring Physician Information:**

**CHIEF COMPLAINT AND PRESENT ILLNESS:**

Area of injury/symptoms Date your symptoms/injury started\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did your symptoms start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis from your doctor ­ Date of your next doctor recheck \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently off work because of this problem no yes; if yes, last day worked?



Using the diagram, circle the specific area of pain. If pain travels, draw arrows.

Please RATE your pain level. No pain 1 2 3 4 5 6 7 8 9 10 Worst pain.

Pain level at your WORST\_\_\_\_\_ BEST\_\_\_\_\_\_ and AVERAGE\_\_\_\_\_

Please DESCRIBE your pain by circling the word or words below?

dull ache\_\_\_\_\_\_\_ burning heavy sore\_\_\_\_\_

deep ache throbbing twinge other\_\_\_\_\_

stabbing squeezing cramp\_\_\_\_\_\_

nagging drawing sharp\_\_\_\_\_\_\_

Are your symptoms intermittent or constant? (circle one)

Do you have any numbness/tingling/weakness? Where?

Prior to this onset, were you free of these symptoms? Yes\_\_\_\_\_ No\_\_\_\_\_ Explain

What eases the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What aggravates the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any other treatment for this problem? What? Chiropractic \_\_\_ Physical Therapy\_\_\_ Other \_\_\_

Did it help? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel you are getting better, getting worse or staying the same? (circle one)

Have you had x-rays? yes no Findings?

Have you had an MRI? yes \_\_\_\_\_\_\_\_ no \_\_\_\_\_\_\_ Findings?

Please list any other tests you have received:

*Women only*: Are you pregnant? yes no Which trimester? 1 2 3

Any other concerns or health changes since the start of this injury/illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACTIVITIES OF DAILY LIVING:** Circle activities that are difficult for you and then check the appropriate box.

|  |  |  |  |
| --- | --- | --- | --- |
|  | no difficulty | with difficulty/pain | cannot perform |
| Personal hygiene: hair, bathing, toilet |  |  |  |
| Dressing: zippers/buttons, upper body, lower body, shoes |  |  |  |
| Household chores: reach overhead, lifting/carrying, dust vacuuming, mopping, Meal Preparation: use stove, do dishes |  |  |  |
| Yard/Garden: mowing, tilling, weeding, raking, watering |  |  |  |
| Walking: stairs, curbs, incline, decline, uneven ground, distancesTransportation: Drive self, ride with others, bus, taxi, shopping |  |  |  |

LIST YOUR LEISURE ACTIVITIES (circle those affected by your current problem):

**GENERAL MEDICAL:** Have you EVER been diagnosed as having any of the following conditions?

|  |  |
| --- | --- |
| A. Cancer YES | K. Other arthritic problems YES |
|  If YES, describe what kind: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | L. Depression YES |
| B. Heart problems YES | M. Hepatitis YES |
| C. High blood pressure YES | N. Tuberculosis YES |
| D. Asthma YES | O. Stroke YES |
| E. Emphysema YES | P. Kidney disease YES |
| F. Chemical dependency (i.e. alcoholism) YES | Q. Anemia YES |
| G. Thyroid problems YES | R. Epilepsy YES |
| H. Diabetes YES | S. Insomnia YES |
| I. Multiple Sclerosis YES | T. Constipation/diarrhea YES |
| J. Rheumatoid arthritis YES | U. Skin Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

If you have been seen by any health care provider during the past 3 months for reasons other than what brought you here, please describe for what reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any SURGERIES you have had or any INJURIES for which you have been treated (please include approximate dates):

Please list ALL PRESCRIPTION and/or OVER-THE-COUNTER medications you are currently taking for this and any

other condition (including pills, injections, and/or skin patches): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have allergy to any medications? If yes, please list them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GOALS:** Please list your personal goals for therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_