Patient History Form

Name: ____ Age: __________ DOB: ________________

Primary Care Physician/Family Physician: ____

Leisure activities, including exercise routines: ____

Occupation: __________________________________ Are you on a work restriction from your doctor? **YES** **NO**

Do you smoke? **YES** **NO** Are you latex sensitive? **YES** **NO**

Do you have a pacemaker? **YES** **NO** Please list any known allergies _________________________

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES** **NO**

Have you RECENTLY noted any of the following (check all that apply)?

- fatigue
- fever/chills/sweats
- nausea/vomiting
- weight loss/gain
- falls
- difficulty maintaining balance
- numbness or tingling
- muscle weakness
- dizziness/lightheadedness
- heartburn/indigestion
- diarrhea
- constipation
- changes in bowel/bladder function
- difficulty swallowing
- shortness of breath
- fainting
- cough
- headaches
- currently feeling down or hopeless

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- Cancer
- Heart problems
- Chest pain/angina
- High blood pressure
- Circulation problems
- Blood clots
- Stroke
- Anemia
- Chemical dependency
- Depression
- Lung problems
- Tuberculosis
- Asthma
- Rheumatoid arthritis
- Other arthritic condition
- Bladder/urinary tract infection
- Sexually transmitted disease/HIV
- Incontinence
- Thyroid problems
- Diabetes
- Osteoporosis
- Fractures
- Multiple sclerosis
- Epilepsy
- Kidney problems
- Ulcers
- Liver problems
- Hepatitis
- Other: _________

Please list prior surgeries and date(s) ____

Date of injury/onset of current symptoms _____________ Date of surgery______________________________

What do you think caused your symptoms?____

Please check any of the following services that you are receiving currently:

Physical Therapy Occupational Therapy Chiropractic Care Massage Therapy Speech Therapy

Have you had any of the following for your current problem: X-Ray Injection MRI CT Scan Other _______

Have you ever had this problem before? **YES** **NO** If yes, when? ______________

In your current living environment: Do you have stairs? **YES** **NO** Do you live alone? **YES** **NO**

How would you rate your overall quality of life? Excellent Good Fair Poor

Please list 3 activities that you are unable to do or having difficulty with as a result of your problem.

1. ____
2. ____
3. ____

Name: ____ DOB:_____________________________

Pain Assessment:

Using the scale below, please select the **WORST** your pain has been during the **past 24 hours**.
0 = no pain, 10 = worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

On the chart to the right, please mark the areas where you feel PAIN with an "**O**" and NUMBNESS/TINGLING with an "**X**".

Back Front

Medication Assessment:
Please list any medications you are currently taking (including pills, injections, skin patches, vitamins, herbs, etc):

Medication Name	Dosage	Frequency	Route of Administration (select how you take this med)
			oral injection patch
			oral injection patch
			oral injection patch
			oral injection patch
			oral injection patch
			oral injection patch
			oral injection patch
			oral injection patch
			oral injection patch

Next referring MD appointment: _______/_______/_______