

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

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

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

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

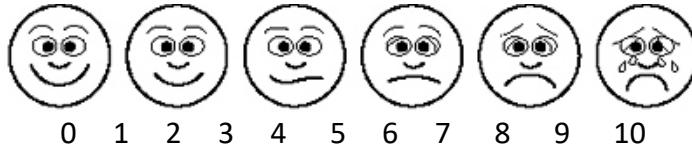
Please list 3 activities that you are unable to do or having difficulty with as a result of your problem.

1. _____
2. _____
3. _____

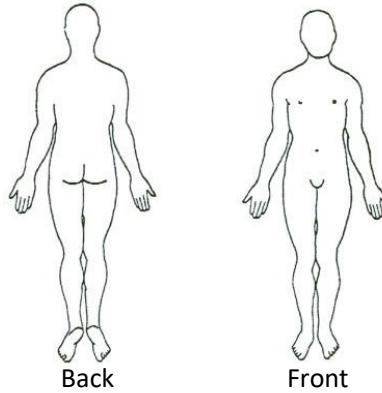
Name: _____ DOB: _____

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



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



Medication Assessment:

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

Next referring MD appointment: _____/_____/_____