

## Patient History

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Referred by \_\_\_\_\_  
Occupation \_\_\_\_\_  
Marital Status S M D W Spouse Name \_\_\_\_\_ Cell phone: (\_\_\_\_\_) \_\_\_\_\_

Please circle for each of the following:

Comments if answer is Yes

### 1. Regarding your Birth Process:

Was the delivery long/difficult? Y N \_\_\_\_\_  
Forceps or extraction used? Y N \_\_\_\_\_  
C-Section? Y N \_\_\_\_\_  
Breach? Y N \_\_\_\_\_  
Home birth? Y N \_\_\_\_\_  
Hospital birth? Y N \_\_\_\_\_

### 2. Growth and Development/ Childhood:

Were you breast fed? Y N \_\_\_\_\_  
Childhood illnesses? Y N \_\_\_\_\_  
Ear infections/ Colic/ Asthma? Y N \_\_\_\_\_  
Attention Deficit? Y N \_\_\_\_\_  
Antibiotics? Y N \_\_\_\_\_  
Drugs, prescription, OTC, recreational? Y N \_\_\_\_\_  
Surgery? Y N \_\_\_\_\_  
Hospitalizations? Y N \_\_\_\_\_  
Sports or other physical activities Y N \_\_\_\_\_  
Injuries during sports? Y N \_\_\_\_\_  
Auto accidents? Y N \_\_\_\_\_  
Did you have other traumas? Y N \_\_\_\_\_  
Did you ever break any bones? Y N \_\_\_\_\_

### 3. Current Health Habits:

Did/do you smoke? Y N \_\_\_\_\_  
Did/do you drink alcohol? Y N \_\_\_\_\_  
Diet, do you eat healthy foods? Y N \_\_\_\_\_  
Have you been in accidents/trauma? Y N \_\_\_\_\_  
Have you had surgery? Y N \_\_\_\_\_  
Drugs, prescription, OTC, recreational? Y N \_\_\_\_\_  
Dental problems? Y N \_\_\_\_\_  
Eye problems? Y N \_\_\_\_\_  
Hearing problems? Y N \_\_\_\_\_  
Exercise regularly? Y N \_\_\_\_\_  
Did/do you have occupational stress? Y N \_\_\_\_\_  
Drive? Daily time spent driving Y N \_\_\_\_\_  
Physical stress? Y N \_\_\_\_\_  
Emotional/Mental stress? Y N \_\_\_\_\_

## Symptoms and Present State of Health

Present complaint/reason for seeking care in this office:

Major \_\_\_\_\_

Pain or Problem started on \_\_\_\_\_

Pains are:  Sharp  Dull/Ache  Constant  Intermittent  Other \_\_\_\_\_

Does this pain shoot, radiate, or travel in your body? Where? \_\_\_\_\_

Are you experiencing numbness or tingling in any area of your body? Where? \_\_\_\_\_

Since it began, is it:  Same  Better  Worst

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is this condition worse during certain times of the day? \_\_\_\_\_

Is this condition interfering with Work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Routine? \_\_\_\_\_ Other? \_\_\_\_\_

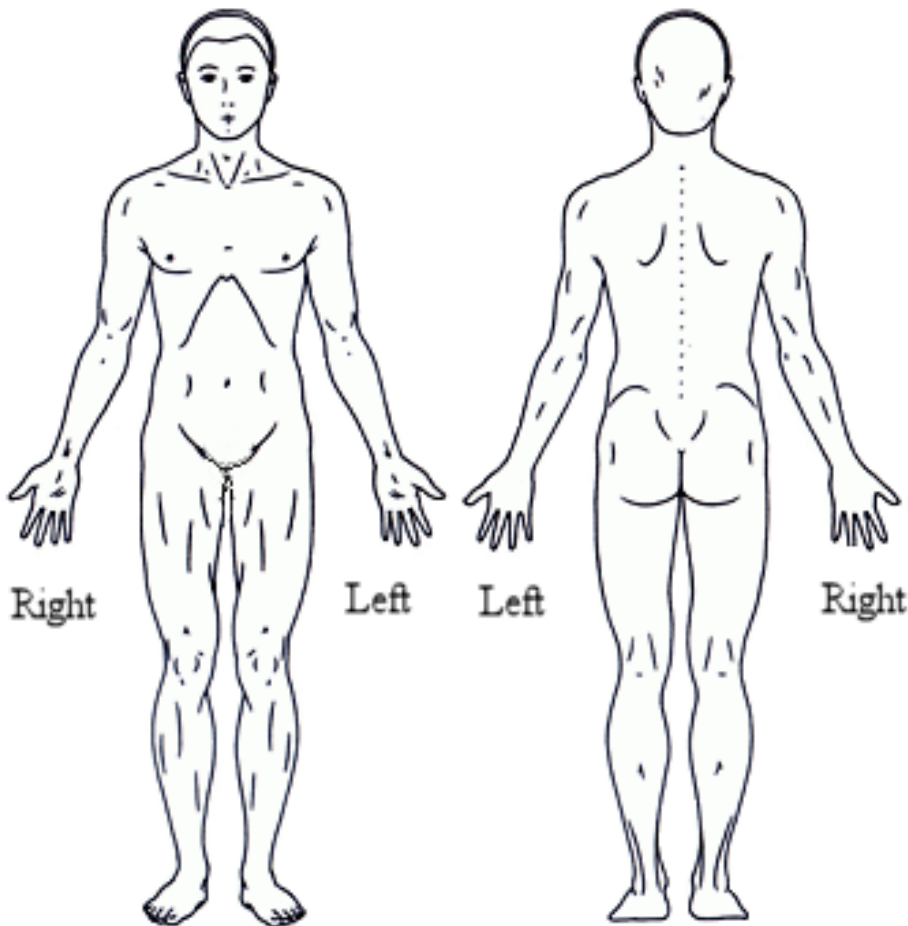
Is this condition progressively getting worse? \_\_\_\_\_

Any physicians seen for this condition \_\_\_\_\_

Any home remedies? \_\_\_\_\_

Please circle where you are at: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain)

Using the symbols below, mark on the pictures where you feel pain.



Numbness = = =

Dull Ache O O O

Burning X X X

Sharp/Stabbing / / /

Pins, Needles + + +

Other \_\_\_\_\_ ^ ^ ^

**Please mark any of the following conditions or symptoms that you have now or have experienced:**

Other Symptoms:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Pain in Hands or Arms     | <input type="checkbox"/> Chest Pains            |
| <input type="checkbox"/> Neck Pain              | <input type="checkbox"/> Numbness in Hands or Arms | <input type="checkbox"/> Heart Attack           |
| <input type="checkbox"/> Sleeping Problems      | <input type="checkbox"/> Pain in Legs or Feet      | <input type="checkbox"/> High Blood Pressure    |
| <input type="checkbox"/> Low Back Pain          | <input type="checkbox"/> Numbness in Legs or Feet  | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Nervousness            | <input type="checkbox"/> Fatigue                   | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Tension                | <input type="checkbox"/> Depression                | <input type="checkbox"/> Painful Urination      |
| <input type="checkbox"/> Irritability           | <input type="checkbox"/> Lights Bother Eyes        | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Loss of Memory            | <input type="checkbox"/> Diarrhea               |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Shoulder Pain             | <input type="checkbox"/> Constipation           |
| <input type="checkbox"/> Neck Stiff             | <input type="checkbox"/> Sinus                     | <input type="checkbox"/> Stomach Upset          |
| <input type="checkbox"/> Joint Swelling         | <input type="checkbox"/> Shortness of Breath       | <input type="checkbox"/> Heartburn/Reflux       |
| <input type="checkbox"/> Fever                  | <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Weight Loss            |
| <input type="checkbox"/> Loss of Balance        | <input type="checkbox"/> Allergies                 | <input type="checkbox"/> Loss of Smell or Taste |
| <input type="checkbox"/> Ringing in Ears        | <input type="checkbox"/> Cold Hands                | <input type="checkbox"/> Menstrual Cramps       |
| <input type="checkbox"/> Jaw/TMJ Problems       | <input type="checkbox"/> Cold Feet                 | <input type="checkbox"/> Menopause              |

Are you under medical care for any condition? \_\_\_\_\_

What medications are you taking? \_\_\_\_\_

How long? \_\_\_\_\_

Have you had surgery? \_\_\_\_\_

What? \_\_\_\_\_

When? \_\_\_\_\_

What side effects have you experienced from the drugs and surgery? \_\_\_\_\_

Females Only –

Date last menstrual period began on \_\_\_\_\_

Are you possibly pregnant? \_\_\_\_\_

**Is there a family history of:**

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>