

Patient Medical History

Please answer all questions thoroughly

NAME _____ AGE _____ OCCUPATION _____ DATE _____

1. For what medical problem/pain are you seeing the doctor?

1. _____
2. _____

2. What date or when did your pain, injury, or problem began?

1. _____
2. _____

3. How did your problem start? (Circle any) suddenly injured at work lifting fall no apparent cause auto accident slowly other (Describe)

1. _____
2. _____

4. What makes the problem worse?

1. _____
2. _____

5. What makes the problem better?

1. _____
2. _____

6. Describe your symptoms by filling out the Pain Diagram given to you by our staff.

7. Does your pain travel anywhere other than the site of injury? (Describe)

1. _____
2. _____

8. Is your pain worse at certain times of the day? (Describe)

1. _____
2. _____

9. Any diagnostic tests/procedures performed for this condition?

(Circle any) x-rays CT scan injections ultrasound MRI nerve conduction study
List other _____
dates: _____

10. Any previous treatment for this condition?

(Circle any) Chiropractic massage acupuncture physical therapy

11. Any previous episodes for this condition? (Describe) i.e.: How often, how severe

12. Any previous surgeries or hospitalization for this problem.

_____ Date _____

_____ Date _____

13. List previous surgeries

_____ Date _____

_____ Date _____

_____ Date _____

14. Do you have any of the following conditions? (Circle any) heart disease diabetes high blood pressure cancer arthritis arteriosclerosis weight loss neurological disorder hypothyroidism
list any others: _____

15. Do you take any medications? List all

16. Do you smoke? Yes/No.

How much? _____ How long? _____

Do you drink alcohol? Yes/No.

How much? _____ How long? _____

17. If female, are you pregnant? Yes/No

18. Family history of any medical problems? (Circle any) diabetes heart disease cancer multiple sclerosis ALS neurological disorders

List others _____
