

HEALTH HISTORY FORM

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PATIENT INFORMATION

Name: _____ Nickname: _____ Date: _____

Age: _____ Gender: _____ Height: _____ Weight: _____ DOB: _____

Are you pregnant? YES NO

Are you: Right Handed Left Handed

Who referred you to us: _____

Who is filling in form: _____ Signature: _____ Relation: _____

By checking this box I affirm my intent to sign this form electronically by typing my name above.

INJURY DETAILS

Are symptoms related to an injury? Y N Work related? Y N Auto accident? Y N

Date of injury: _____ Are you currently working? Full Duty Light Duty Not Working

List your work restrictions: _____

Employer: _____ Occupation: _____

PROBLEM DETAILS

Body Part to be examined: RIGHT LEFT _____

Date of symptom onset: _____ Current pain score (1-10): _____ Pain score at worst: _____

How did the problem begin (give details):

What activities make pain worse: _____

What makes pain better: _____

Describe pain: Ache Sharp Stabbing Throbbing Tingling Burning other: _____

Do you have: Weakness Stiffness Loss of motion Locking Catching Giving way Popping

Who have you seen for this: ER/Urgent Care Family Dr. Work Comp Dr. Chiro PT

Have you seen a surgeon for this: YES NO Whom/when: _____

Previous treatments: Ice Compression Bracing PT Chiropractor Massage Injections

MEDICAL TEAM

Who is your primary care provider: _____ Phone #: _____

Preferred pharmacy name/location: _____ Phone #: _____

ALLERGIES

Are you allergic to any medications? Y N Adhesives? Y N Metal/jewelry? Y N

Please list all allergies: _____

MEDICATIONS

Please list all current medications (include prescriptions, over-the-counter & supplements):

Medication name

Dose

Medication name

Dose

MEDICAL HISTORY

Please mark all current & past medical conditions:

CV: Heart disease Heart attack Irregular heart beat Stroke

Pulm: Lung disease COPD Asthma Sleep apnea

GI: Ulcers Crohn's/UC Gastric bleeding

GU: Kidney disease ID: Hepatitis HIV/AIDS TB

Endo: Diabetes (A1c:_____)

Onc: Cancer (type:_____)

Neuro: Seizure disorder Neuropathy

MSK: Lupus Rheumatoid arthritis Gout Fibromyalgia Osteoporosis

Psych: Depression Anxiety Bipolar. Heme: Blood clots Bleeding Disorder

Please list any other medical conditions not already listed:

SURGICAL/HOSPITAL HISTORY

Please list all past surgeries and hospitalizations:

Surgery/Condition

Date

Surgery/Condition

Date

SOCIAL HISTORY

Do you smoke? YES NO Packs per day: _____ For how long: _____ Quit date: _____

Do you drink alcohol? YES NO Drinks per week: _____ Do you use rec. drugs? YES NO

FAMILY HISTORY

Do you have a family history of blood clots? YES NO

Has any one in your family had a significant reaction to anesthesia? YES NO

If yes, please explain: _____

Hobbies

Please list all of your hobbies, including sports: _____