

Patient History

Name: _____ DOB: _____

Referring Doctor: _____ Primary Care Doctor: _____

Reason for Visit/Chief Complaint: _____

When did this complaint start? _____

Have you done any of the following for this complaint (please check all that apply)?

Physical Therapy (duration, date of last visit and where)		Chiropractic treatment	<input type="checkbox"/>
Over-the-counter meds (please list and for how long)		Heat	<input type="checkbox"/>
Injections (include doctor's name and when)		Ice	<input type="checkbox"/>

	Y (include date of injury)	N
Is the problem work related?	<input type="checkbox"/>	<input type="checkbox"/>
Are we filing Workman's Comp?	<input type="checkbox"/>	<input type="checkbox"/>
Is this related to an auto accident?	<input type="checkbox"/>	<input type="checkbox"/>
Are you on disability? If so, why and since when?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY Please check those that apply to you.

Condition	Y	Condition	Y	Condition	Y	Condition	Y
Hypertension	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	Pulmonary Embolus	<input type="checkbox"/>	Parkinson's	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	COPD	<input type="checkbox"/>	Tremor	<input type="checkbox"/>	Suicide Attempt	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	DVT	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>
Bleeding/Clotting disorder	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	Bipolar disorder	<input type="checkbox"/>
Hypothyroid	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Anorexia/Bulimia	<input type="checkbox"/>
Hyperthyroid	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Sexual Abuse	<input type="checkbox"/>
Thyroid Goiter/Nodule	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	Cancer (type):	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>		
Diabetic Neuropathy	<input type="checkbox"/>	Bleeding Ulcer	<input type="checkbox"/>	Post Laminectomy Syndrome	<input type="checkbox"/>		
Other: _____							

Trauma History: _____

Past Surgeries and Dates: _____

SPINE/ PAIN HISTORY (please check if applicable): I have Chronic Pain in my: Neck / Back / Both

 Name of Pain Clinic: _____ Pain Contract: Yes – Start date: _____ / No

 Have you ever been discharged from a pain clinic for breaking a pain contract? (please check) Y / N

Patient History

Review of Systems: Please check only those that currently apply to you.

CONSTITUTIONAL		GASTROINTESTINAL		GENITOURINARY	
Weight Loss	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Pain Urinating	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	Nausea/ Vomiting	<input type="checkbox"/>	Frequency	<input type="checkbox"/>
Fever	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Nighttime Frequency	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	Difficulty Starting to Urinate	<input type="checkbox"/>
CARDIOVASCULAR		Jaundice	<input type="checkbox"/>	Difficulty Emptying Bladder	<input type="checkbox"/>
Murmur	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	History of Kidney Stones	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	Erectile Dysfunction	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	NEUROLOGICAL		Retrograde Ejaculation	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	EYES	
Difficulty Breathing when Lying Flat	<input type="checkbox"/>	Weakness/ Paralysis	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>
Swelling Ankles/ Other	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>
MUSCULOSKELETAL		Tremors	<input type="checkbox"/>	HEMATOLOGIC/ LYMPH	
Joint Pain/ Swelling	<input type="checkbox"/>	Headache	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>
Stiffness	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>
Muscle Pain	<input type="checkbox"/>	Trouble finding words	<input type="checkbox"/>	ALLERGIC/ IMMUNOLOGIC	
Back Pain	<input type="checkbox"/>	Balance Problems	<input type="checkbox"/>	Hay Fever/ Asthma	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	EAR, NOSE, THROAT		Hives/Eczema	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	Difficulty Hearing	<input type="checkbox"/>	HIV	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	Ringing in Ears	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>
ENDOCRINE		Dizziness	<input type="checkbox"/>	MRSA/ VRE	<input type="checkbox"/>
Loss of Hair	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	SKIN	
Heat/ Cold Intolerances	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	Rash	<input type="checkbox"/>
Change in Nails	<input type="checkbox"/>	RESPIRATORY		Lesions	<input type="checkbox"/>
PSYCHIATRIC		Cough	<input type="checkbox"/>	FEMALE ONLY	
Anxiety/ Depression	<input type="checkbox"/>	Coughing Blood	<input type="checkbox"/>	Menopause	<input type="checkbox"/>
Mood Swings	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Are Periods Regular?	<input type="checkbox"/>
Difficult Sleep	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	OTHER? _____	

How many flights of stairs can you climb before you get short of breath? _____

SOCIAL HISTORY

Do you currently...	Y	N
Smoke / Dip / Chew tobacco?	Packs/Day _____ How long? _____	<input type="checkbox"/>
Consume alcohol?	Beverages/week: _____	<input type="checkbox"/>
Illegal use of drugs? (please list)		<input type="checkbox"/>
Have you ever had a problem with drugs and/or alcohol? If so, which one?		<input type="checkbox"/>
If you quit any of the above, please indicate which one, amount of prior usage, and when quit.		

Marital Status (please check): Married Single Divorced Separated Widowed Partner

How many children do you have? _____

Patient History

Education (please enter highest grade completed):

Grade School _____ High School _____ Vocational _____ College _____ Post Graduate _____

Current Occupation: _____ Former Occupation: _____

Dietary Status (please check): Meat and Vegetables Vegetarian Vegan Other: _____

Restrictions: _____

Medication Allergies/Reaction: _____

MEDICATIONS (Please list any additional medications you are taking on a separate sheet of paper)

Medication	Dose	Frequency	For

FAMILY HISTORY

Family Members	Living?	If Deceased, Age When Died and Cause of Death
Mother		
Father		
Sister(s)		
Brother(s)		

Family History of...	Y		Y		Y
Hypertension	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Alcohol/Drug Abuse	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	Suicide	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	Cancer (indicate type)	<input type="checkbox"/>
Spine Surgery	<input type="checkbox"/>	Brain Surgery	<input type="checkbox"/>	Brain Tumor	<input type="checkbox"/>
Brain Aneurysm	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>		