PATIENT HISTORY SHEET

Height__________ Weight___________

Name: ____ Age: _______ Occupation: _______________________________

List allergies or drug reactions: ____

List all medications you are currently taking: (or provide copy of list) ____________________________________

____

Body part: _________________________ ☐ L ☐ R ☐ Both Date of injury or when symptoms began: _______________

How did the injury occur?: ____

Symptoms:____

What makes your symptoms better? ______________________________Worse?__________________________

Have you been treated by another physician, chiropractor, or therapist regarding this injury? ☐ Yes ☐ No

(If yes please explain)____

Have you had any of the following exams in regards to this injury?

	Yes	No	When/Where		Yes	No	When/Where
X-ray	☐	☐	______________	Arthrogram	☐	☐	______________
MRI	☐	☐	______________	Myelogram	☐	☐	______________
CT	☐	☐	______________	EMG	☐	☐	______________
Other ______________				Other ______________			

Do you have any family history of similar medical/orthopedic problems? ___________________________________

List any previous hospitalizations/surgeries:____

Check any medical conditions you or your immediate family have now or have had in the past:

	Self	Family	None		Self	Family	None		Self	Family	None
High blood pressure	☐	☐	☐	Heart disease	☐	☐	☐	Sleep Apnea	☐	☐	☐
Diabetes	☐	☐	☐	Liver disease	☐	☐	☐	______________	☐	☐	☐
Cancer	☐	☐	☐	Kidney disease	☐	☐	☐	______________	☐	☐	☐

Do you smoke? ☐ Yes ☐ No How many packs per day?:____

Do you consume alcohol? ☐ Yes ☐ No If yes, describe amount: ____

Do you follow a routine exercise program? ☐ Yes ☐ No If yes, describe:___________________________________

REVIEW OF SYSTEMS:

Have you experienced or are you experiencing any of the following?

	Yes	No		Yes	No		Yes	No
Constant fatigue	☐	☐	Swollen glands	☐	☐	Frequent diarrhea	☐	☐
Weight loss/gain	☐	☐	Chronic cough	☐	☐	Urinary discharge	☐	☐
Fever	☐	☐	Anemia	☐	☐	Urinary frequency	☐	☐
Chills	☐	☐	Bruising	☐	☐	Muscle cramps	☐	☐
Frequent headaches	☐	☐	Shortness of breath			Tremors	☐	☐
Rashes	☐	☐	with exertion	☐	☐	Anxiety	☐	☐
Nail changes	☐	☐	Recurrent nosebleeds	☐	☐	Sleep disturbance	☐	☐
Dizzy spells	☐	☐	Nausea	☐	☐	Depression	☐	☐
Ringing in the ears	☐	☐	Vomiting	☐	☐			

If you are being seen for your back or neck please complete the following section.

Your pain is *(check appropriate boxes):*

	Better	Worse	No Different		Better	Worse	No Different
When coughing or sneezing	☐	☐	☐	Upon awakening	☐	☐	☐
Sitting in a straight chair	☐	☐	☐	Midday	☐	☐	☐
Sitting in an easy chair	☐	☐	☐	In the middle of the night	☐	☐	☐
Bending forward	☐	☐	☐	Lying flat on your back	☐	☐	☐
Driving/Riding in a car	☐	☐	☐	Lying flat on your stomach	☐	☐	☐

____ ________________

Patient Signature Date