Health History Form

Drs. Christina & Jeffrey Carter

Patient Name: _____ **Date**: _____

Main Problem

What pain(s) or condition(s) caused you to come to the office? _____

_____

_____

What caused the pain(s) or condition(s)? _____

Were you in a car accident? □ No. □ Yes. Did you fall? □ No. □ Yes. Any other event? □ No. □ Yes, _____

When did this pain start? _____ Have you had this before? _____

How bad is the pain? (Circle the one that applies) Mild Moderate Severe Intolerable

Please rate your pain. (Circle a number or a range. 10 is the worst pain.) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Please describe your pain. (Circle all that apply) Cramp Ache Dull Sharp Shooting Throbbing Burning
Pressure Deep Stinging Lightening Pins & Needles Numb

Do you feel you are having spasms? □ No. □ Yes, where? _____

Do you feel weak? □ No. □ Yes, where? _____

How often does the pain occur? (Circle the one this applies) Rarely Occasional Frequent Constant

Does this pain travel to any other area? _____

What makes this pain better? (ex. Heating pad, pain killers, sitting) _____

_____

What makes this pain worse? (ex. Standing, reading, gardening) _____

_____

What else have you done to treat this pain? (ex. Medication, surgery, MRI) _____

_____

Other Problem(s)

What other pain or conditions do you have? _____

_____

What else should we know about this pain or condition? _____

_____

_____

Allergies - Please list any allergies below including allergies to medications.

_____

_____

Women only - Are you pregnant? □ No. □ Yes. Are you trying to get pregnant? □ No. □ Yes.

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Family History – Tell us about the health of your family. Check the boxes of conditions that apply.

	Heart Disease	Stroke	Cancer	Diabetes	Arthritis	Multiple sclerosis	Scoliosis
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐	☐

Social History - please circle the response that applies to you.

Are you employed? NO YES Do you drink alcohol? NO YES Do you have a **pacemaker**? NO YES

Do you use tobacco? NO YES Have you used tobacco in the past? NO YES

Past Health History - please give details when it applies to the reason you are here.

Have you had any illnesses in the past? _____

_____

Have you had any injuries in the past? _____

_____

Have you had any type of cancer? _____ _____

_____ _____

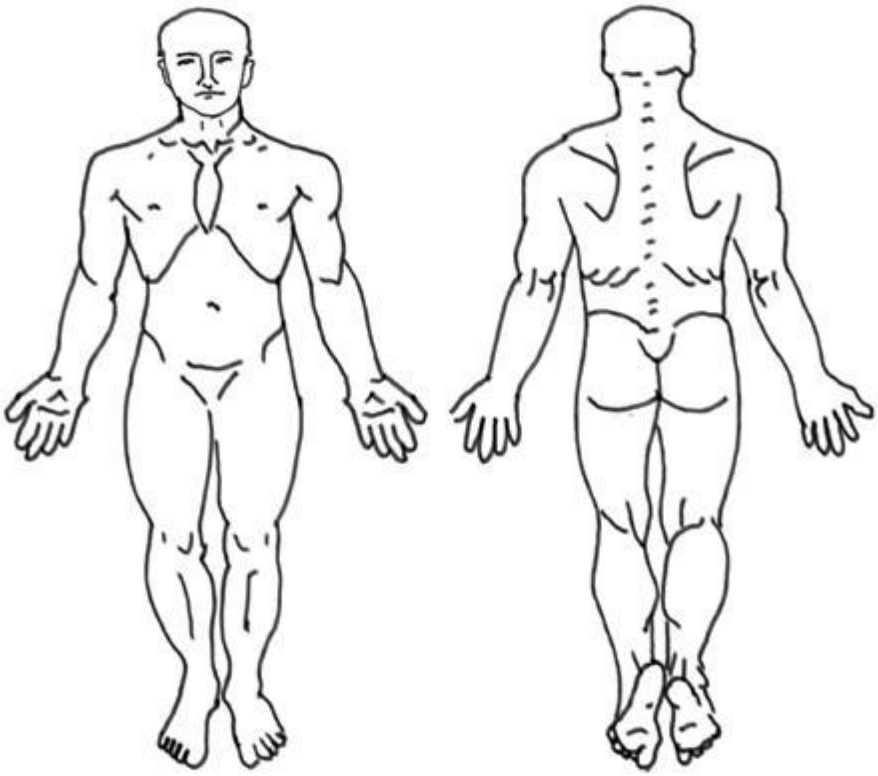
Have you ever had surgery or been hospitalized? _____ _____

_____ _____

Please list any medications you are taking: (both over the counter & prescription)_____

_____ _____

Pain Drawing – Please indicate your areas of pain on the drawing below.



Don't forget to sign!

Patient Signature: _____ **Date**: _____

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