Health History Form

Patient Name: _____ Date: _____

Main Problem -

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

_____

_____

Were you in a car accident? □ No □ Yes Did you fall? □ No □ Yes

Any other cause for this pain □ No □ Yes, what? _____

When did this pain start? _____ Have you had this before? □ No □ Yes

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

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

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

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

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

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

Does this pain travel to any other area? □ No □ Yes, where? _____

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

_____

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

_____

Whether or not it helped the pain, what else have you done to treat this pain? (Circle all that apply)

Acupuncture Chiropractic Massage Over-the-Counter Medication Pain Shots Physical Therapy Prescription Medication Surgery Anything else? _____

Have you had any previous imaging for this pain? (If yes, circle all that apply) □ No □ Yes, X-ray MRI CT

Other Problem(s) -

What other pain or conditions do you have? _____

_____

Past Health History -

Have you had any illnesses or injuries in the past? (If yes, explain) _____

_____

Have you had any type of cancer? (If yes, explain) _____

_____

Have you ever had surgery or been hospitalized? (If yes, explain) _____

_____

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

_____

Family History - 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	☐	☐	☐	☐	☐	☐	☐

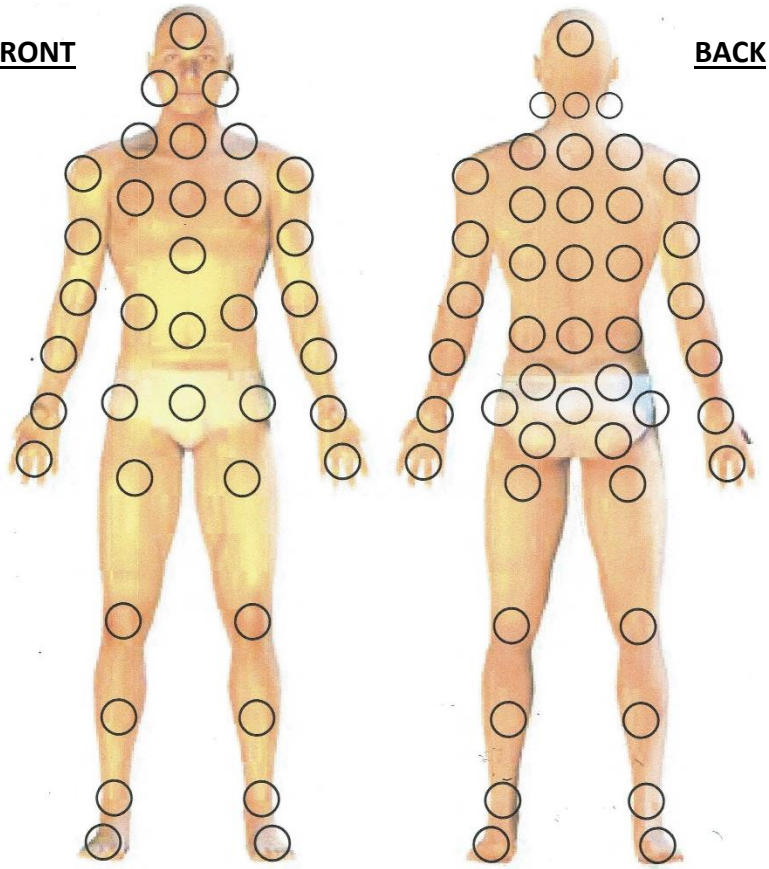
Social History -

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

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

Pain Drawing - Indicate your areas of pain by marking the circles that correspond with your areas of pain.



Don't forget to sign!

Patient Signature: _____ **Date**: _____