PATIENT HISTORY FORM

Date: / /

NAME: ______________________________________ Birthdate: / /

Last First M. I.

Age: Sex: M ❑ F ❑

Height: Weight:

Address:

Phone:(Home) (Cell):

Email:

Emergency contact Name & Number
and relation:

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen
for this problem:

Primary care doctor:

List past/current treatments you've had for this condition:

Circle any imaging you have had: X-ray MRI EMG Doppler Ultrasound CT scan
blood work bone scan

 PT initials ________

PERSONAL HISTORY

Were there any problems with your birth or any childhood medical diagnoses?

What is your current or past occupation?

Are you currently working? ❑ Yes ❑ No

Hours/week ______

If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No

If yes, for what disability & how long ?__________________________

List if you know the cause of your current injury:

Have you fallen 2 or more times in the past year?

PAST MEDICAL HISTORY

Check if you now or have ever had:

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Blood Clot
❑ Headaches
❑ Cancer (type/yr) _______________
❑ Bowel/Bladder Problems
❑ Hearing problems
❑ Vision problems
❑ Heart problems

❑ Pneumonia
❑ Hepatitis
❑ Asthma
❑ Other breathing problems
❑ Stroke
❑ Epilepsy (seizures)
❑ HIV/AIDS
❑ Kidney disease
❑ Kidney stones

❑ Lupus
❑ Ulcers
❑ Thyroid disorder
❑ Multiple Sclerosis
❑ Dizziness/Fainting
❑ Depression
❑ Lyme Disease
❑ Pregnant

List ANY other medical conditions:

List Surgeries:

SUBSTANCE USE

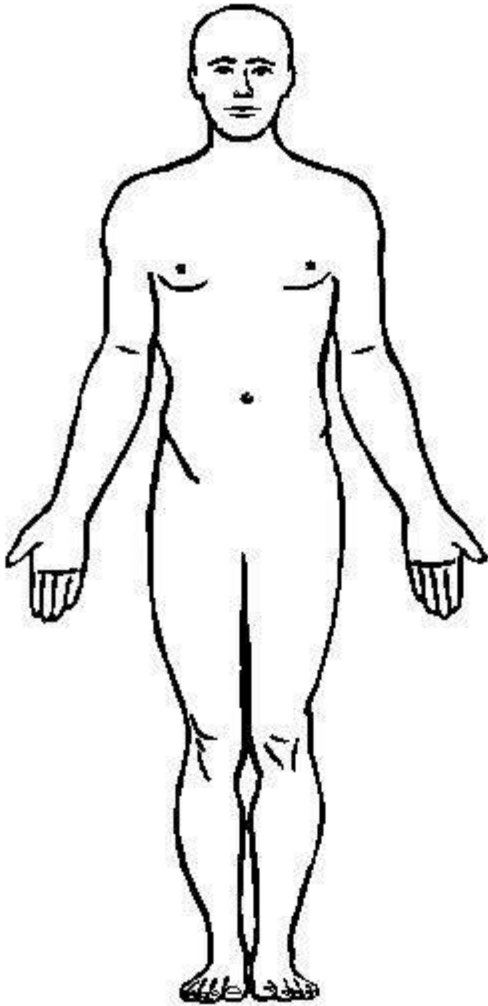
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often do you use this?	How many years do you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes □ No □
SMOKING/TOBACCO/OTHER DRUGS					Yes □ No □
OVER THE COUNTER MEDICINE/PILLS (please list)					Yes □ No □
PRESCRIBED MEDICINE/PILLS (please list)					Yes □ No □

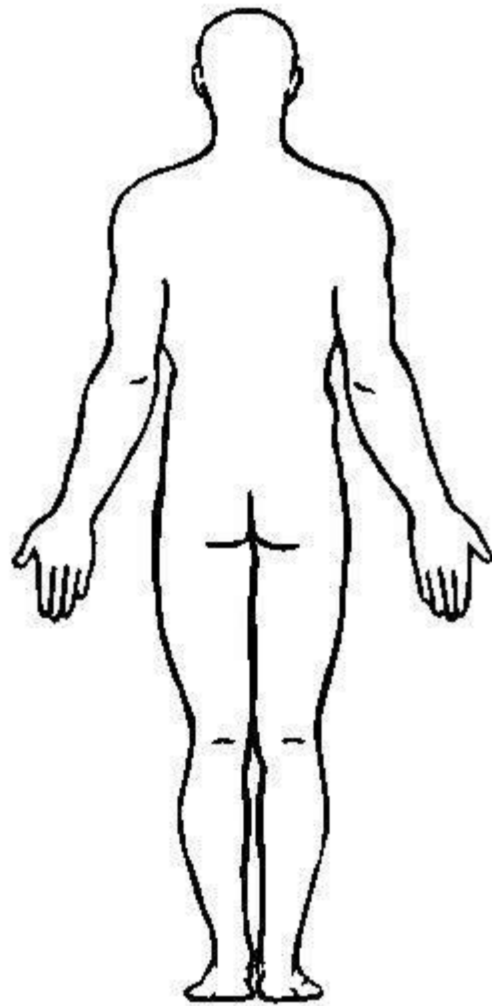
Patient Signature:_______________________________________ **Date**:_________________________

PT initials _______

Where is your pain?

Please circle where you hurt





Please rate your pain on 0-10 scale (0 is no pain, 10 is the worst you can imagine):

Best: 0 1 2 3 4 5 6 7 8 9 10 **Worst**: 0 1 2 3 4 5 6 7 8 9 10 **Present:** 0 1 2 3 4 5 6 7 8 9 10

PT initials _______