Patient History Information

Patient Name: _____ **Todays Date**: _____

Date of Birth: _____ Age: _____ Marital Status:_____

Occupation:_____ Height: _____ Weight: _____

Dominant Hand: RIGHT LEFT

Please describe your problem:_____

_____

Date of onset? _____ Is your problem due to an injury? YES NO

If injury, how did it happen?_____

_____

DID IT HAPPEN ON THE JOB? **YES** **NO** DID YOU REPORT IT TO YOUR SUPERVISOR? **YES** **NO**

How did the pain start? _____

DESCRIBE YOUR SYMPTOMS: _____

_____

Does the pain radiate? YES NO If so, where?_____
_____

Do you experience paresthesias (numbness, tingling, pins and needles, burning) and if so, where? _____
_____

Do you have weakness? YES NO If so, where?_____

Do you have any bladder or bowel issues? If so, please describe:_____

Do you notice any of the following?

Swelling	Catching	Locking	Tingling
Grinding	Numbness	Other: _____	

Please CIRCLE the number that best describes your pain on a scale of 1-10:

⇨ 1 2 3 4 5 6 7 8 9 10 1 = hardly any pain 10 = terrible pain

What activities make your pain worse?

EXERCISE	SITTING	STANDING	REACHING UP
WALKING	BENDING FORWARD	BENDING BACKWARD	REACHING FORWARD
COUGHING	SNEEZING	LIFTING	OTHER_____

What activities make the pain better?

LYING DOWN	SITTING	WALKING	OTHER_____
MANIPULATION	NOTHING	MEDICATION	

What previous treatments have you tried?_____

Have you had previous surgery on your spine?_____

Are you claustrophobic (uncomfortable in enclosed areas)? YES NO

Do you have any retained metal (e.g., metal joints, pins, pacemaker) YES NO If yes, WHERE_____

Do you smoke? YES NO
If yes, how long? _____ How many packs per day? _____
Do you use alcohol in any form? YES NOIf yes, how long? _____ How much? _____

PLEASE ALSO COMPLETE THE OTHER SIDE OF FORM

FAMILY PHYSICIAN _____

CARDIOLOGIST _____ **Pharmacy** _____

PLEASE LIST MAJOR MEDICAL ILLNESSES (e.g., High Blood Pressure, Heart Disease, diabetes, cancer, etc.).

Illness	Date Diagnosed

PLEASE LIST PREVIOUS OPERATIONS OR HOSPITALIZATIONS AND DATES,

Type of Operation or Hospitalization	Date

PLEASE LIST ALL MEDICATIONS AND DOSAGES TAKEN WITHIN THE LAST YEAR, INCLUDING NONPRESCRIPTION MEDICATIONS SUCH AS ASPIRIN AND VITAMINS.

Medication & Dosage	Frequency

LIST ALLERGIES TO MEDICATIONS:_____

Please list any **FAMILY HEALTH PROBLEMS**, such as cancer; heart, lung or kidney disease; stroke; hypertension; or allergies?_____

PERSONAL HEALTH HISTORY
(Please circle all that apply)

General Constitutional	Recent weight gain, Recent weight loss, Fever, Chills, Sweats
Eyes	Blurry vision, Double vision
Ear, Nose, Mouth, Throat	Hearing loss, Dizziness, Tooth or gum disease
Cardiovascular	Chest pain, Heart attack, Skipping heartbeat, High blood pressure, Shortness of breath, Heart murmur, Heart disease
Respiratory	Pneumonia, Chronic cough, Tuberculosis, Coughing up blood, Wheezing, Asthma
Gastrointestinal	Heartburn, Diarrhea, Black stools, Bloody stools, Ulcers, Yellow skin, Constipation
Genitourinary	Frequent urination, Difficulty urinating, Bloody urine WOMEN: Excessive bleeding during periods, Bleeding between periods Pregnancies MEN: Difficulty starting urinary stream, Difficulty maintaining erections
Musculoskeletal	Muscle pain, Joint pain or swelling, Arthritis
Skin	Rashes, Ulcers, Infection
Neurologic	Numbness, Tingling, Weakness, Seizures, Loss of coordination
Psychiatric	Emotional problems, Anxiety, Depression, Mood swings
Endocrine	Diabetes, Thyroid or other glandular problems
Hematological	Anemia, Easy bruising, Easy bleeding

_____ _____

Date: Patient Signature Physician Initials - Reviewed