Confidential Patient History Form

Name: ___________________________________ **Date:** ___________________

This form should be filled out before your first visit. Please fill it out as completely as possible. The first section relates to your MAIN complaint.

1. Is this complaint related to: Auto Accident ____ Work injury ____ Other ___________________________

2. Please describe the location and type of symptoms that pertain to your MAIN complaint:

Location of symptoms: head ____ neck ____ shoulder ____ upper back ____ mid back ____ low back ____ hip ____ thigh ____ lower leg ____ankle ____ foot ____ elbow ____ forearm ____ wrist ____ hand ____ jaw ____ chest ____

If other, please describe: ____

Is the problem on the: right side ____ left side ____ both sides ____ **If both, which is worse?** right ____ left ____ equal ____

How would you describe your symptoms? Pain ____ stiffness ____ weakness ____ numbness ____ dizziness ____ irritability ____ anxiety ____ loss of sensation ____ blurred vision ____

Please describe any symptoms you are having that weren't listed above:_________________________________
____

Indicate any activities of daily living that are affected: sitting ____ standing ____ reaching ____ sleeping ____ bending ____ walking ____ climbing stairs ____ sneezing ____ coughing ____ pulling ____ pushing ____ breathing ____ turning ____ grasping ____ driving ____ lifting ____ exercise ____ sports ____

Please list affected sports and exercise: ____

How would you describe the affect on these activities over time? improving ____ getting worse ____ about the same ____

3. How often do you experience your symptoms? Constantly (76-100% of the time) ____
Frequently (51-75% of the time) ____Occasionally (26-50% of the time) ____
Intermittently (1-25% of the time) ____

4. How would you describe your pain? sharp ____ dull ____ diffuse ____ achy ____ burning ____ shooting ____ stiffness ____ numb ____ tingly ____ sharp with motion ____ shooting with motion ____ electric-like with motion ____**Other:** ____

5. How are your symptoms changing with time? Getting better ____ getting worse ____ about the same ____

6. Using a scale of 0-10 (10 being the worst) how would you rate your problem?
Please circle one: 0 1 2 3 4 5 6 7 8 9 10

7. How much has the problem interfered with your work? not at all ____ a little bit ____ moderately ____ quite a bit ____ extremely ____

8. How much has the problem interfered with your social activities? not at all ____ a little bit ___ moderately ____quite a bit ____ extremely ____

9. Who else have you seen for this problem? chiropractor ____ neurologist ____ primary care physician ____ ER physician ____ orthopedist ____ massage therapist ____ physical therapist ____ acupuncturist ____ no one ____Other, please list ____

10. When did this problem begin? ____

11. How did your problem begin? ____

12. What aggravates your problem? ____

13. What makes it feel better? ____

14. What concerns you the most about the problem? What does it prevent you from doing? _______________
____

Please list the location and type of symptoms related to your SECONDARY complaint:
Skip this section if you are only here for one complaint.

1. Is this complaint related to: Auto Accident ____ Work injury ____ Other ______________________________________

2. Please describe the location and type of symptoms that pertain to your SECONDARY complaint:
Location of symptoms: head ____ neck ____ shoulder ____ upper back ____ mid back ____ low back ____ hip ____ thigh ____ lower leg ____ankle ____ foot ____ elbow ____ forearm ____ wrist ____ hand ____ jaw ____ chest ____
If other, please describe: ____
Is the problem on the: right side ____ left side ____ both sides ____ **If both, which is worse?** right ____ left ____ equal ____
How would you describe your symptoms? Pain ____ stiffness ____ weakness ____ numbness ____ dizziness ____ irritability ____ anxiety ____ loss of sensation ____ blurred vision ____
Please describe any symptoms you are having that weren't listed above: ______________________________
____
Indicate any activities of daily living that are affected: sitting ____ standing ____ reaching ____ sleeping ____ bending ____ walking ____ climbing stairs ____ sneezing ____ coughing ____ pulling ____ pushing ____ breathing ____ turning ____ grasping ____ driving ____ lifting ____ exercise ____ sports ____
Please list affected sports and exercise: ____
How would you describe the affect on these activities over time? improving ____ getting worse ____ about the same ____

3. How often do you experience your symptoms? Constantly (76-100% of the time) ____ Frequently (51-75% of the time) ____Occasionally (26-50% of the time) ____ Intermittently (1-25% of the time) ____

4. How would you describe your pain? sharp ____ dull ____ diffuse ____ achy ____ burning ____ shooting ____ stiffness ____ numb ____ tingly ____ sharp with motion ____ shooting with motion ____ electric-like with motion ____
Other: ____

5. How are your symptoms changing with time? getting better ____ getting worse ____ about the same ____

6. Using a scale of 0-10 (10 being the worst) how would you rate your problem?
Please circle one: 0 1 2 3 4 5 6 7 8 9 10

7. How much has the problem interfered with your work? Not at all ____ a little bit ____ moderately ____ quite a bit ____ extremely ____

8. How much has the problem interfered with your social activities? Not at all ____ a little bit ____ moderately ____quite a bit ____ extremely ____

9. Who else have you seen for this problem? chiropractor ____ neurologist ____ primary care physician ____ ER physician ____ orthopedist ____ massage therapist ____ physical therapist ____ acupuncturist ____ no one ____Other, please list ____

10. When did this problem begin? ____

11. How did your problem begin? ____
____

12. What aggravates your problem? ____

13. What makes it feel better? ____

14. What concerns you the most about the problem? What does it prevent you from doing?
____
____

Health and History

1. What is your current height? _____________ **Your current weight?** ________________

2. How would you rate your overall health? excellent ____ very good ____ good ____ fair ____ poor ____

3. What type of exercise do you do? Strenuous ____ moderate ____ light ____ none ____ yoga ____
weight lifting ____ running ____ cycling ____ walking ____ tennis ____ triathlon ____ hiking ____ rowing ____
swimming ____ Pilates ____core strength ____ golf ____ soccer ____ basketball ____ volleyball ____ skiing ____
martial arts ____ stretching ____
Other, please list: ____

4. Please indicate whether any of your immediate family members have any of the following conditions:
arthritis ____ diabetes ____neck or back pain ____ heart disease ____ cancer ____ stomach disorders ____
stroke ____neurologic disorders ____ circulation disorders ____
other serious conditions: ____

5. For each of the conditions below, select the ones that you have had in the Past: headaches ____
high blood pressure ____ diabetes ____ stroke ____ heart problems ____ excessive thirst ____
kidney disorders ____ chest pains ____ urinary tract disorders ____ allergies ____ dermatitis/eczema/rash ____
depression ____ epilepsy ____ osteopenia/osteoporosis ____ drug/alcohol dependence ____ cancer ____
loss of appetite ____abdominal pain ____arthritis ____ hepatitis ____ asthma ____ muscular in-coordination ____
liver/gall bladder disorder ____ dizziness ____ excessive fatigue ____
other conditions: ____

6. For each of the conditions below please select the ones you have PRESENTLY: headaches ____
high blood pressure ____diabetes ____ stroke ____ heart problems ____ excessive thirst ____
kidney disorders ____ chest pains ____ urinary tract disorders ____ allergies ____ dermatitis/eczema/rash ____
depression ____ epilepsy ____ osteopenia/osteoporosis ____ drug/alcohol dependence ____ cancer ____
loss of appetite ____ abdominal pain ____ arthritis ____ hepatitis ____ asthma ____ muscular in-coordination
____ liver/gall bladder disorder ____ dizziness ____ excessive fatigue ____
other conditions: ____

7. Please list all prescription medications you are currently taking: _____________________________________
____

8. Please list all over-the-counter medications you are taking: ____
____

9. Please list all surgical procedures you have had, including approximate dates: __________________________
____

10. Which activities do you do at work? Sit: most of the day ____ half the day ____ a little of the day ____
Stand: most of the day ____ half the day ____ a little of the day ____ **computer work**: most of the day ____
half of the day ____ a little of the day ____ **on the phone**: most of the day ____ half of the day ____
a little of the day ____
Other work activities: ____
____

11. What activities do you do outside of work? ____
____

12. Have you ever been hospitalized**?** Yes ____ no ____ **If yes, please explain:** ___________________________
____

13. Have you had any significant past trauma? Yes ____ no ____ **If yes, please explain:** ____________________
____

14. Is there anything else pertinent to your visit? ____
____

15. Date of last: physical exam**:** _____________ X-ray: _____________ spinal evaluation: _____________
MRI/CT Scan: _____________ Blood test: _____________ Urine test: _____________
16. Social history/habits: no alcohol ____ 1-2 alcohol drinks/week ____ 3-4 drinks/week ____
5 or more drinks/week ____ no caffeine ____ caffeine 1-3/day ____ caffeine >3/day ____
no nicotine ever ____ no nicotine 1-3 years ____ no nicotine 3-5 years ____ no nicotine >5 years ____
using nicotine now ____
no exercise ____ exercise 1-2 days/week ____ exercise 2-4 days/week ____ exercise >4days/week ____
17. Do you have a pacemaker or other metal implant? Yes ____ no ____
please explain a yes answer: ____
18. Females, are you pregnant? no ____ yes ____ if yes, when are you due? _____________
19. Sleep position: Primary: back ____ stomach ____ left side ____ right side ____both sides ____
Secondary: back ____ stomach ____ left side ____ right side ____ both sides ____
20. Hand dominance: right handed ____ left handed ____
21. Have you recently experienced: bowel or bladder changes? yes ____ no ____
If yes, please explain: ____
Difficulty breathing? Yes ____ no ____ If yes, please explain: ____
Chest pains? Yes ____ no ____ If yes, please explain:____
Feeling light-headed or having difficulty breathing? Yes ____ no ____ If yes, please explain: _________________
____
Headaches? Yes ____ no ____ If yes, please explain: ____
Fevers? Yes ____ no ____ If yes, please explain: ____
22. Health goals/reason for this visit: symptom relief ____ injury prevention ____
improve athletic performance ____weight loss ____ increase flexibility ____ improve quality of life ____
increase mobility ____ other ____
23. Who is your primary physician? ____
Where does he/she practice? ____
____