


Patient History

Name _____ Age _____ Date of Injury or Onset of Symptoms _____

Describe your current problem & where it is (i.e. low back pain, tingling in feet) _____

What were circumstances in which the problem occurred? _____

Have you been under the care of another physician for this problem? Yes No Name _____

Rate your pain: 
(no Pain) 0 1 2 3 4 5 6 7 8 9 10 (worst Pain)
Worst Day # _____ Best Day # _____ Today # _____

What makes your pain worse? (please circle all that apply)
 Sitting Bending Forward Exercising
 Standing Bending backward Coughing
 Walking Lifting Driving
 Other _____

What makes you pain better? (please check all that apply)
 Sitting Exercising Lying down
 Standing Medications Massage
 Walking Heat Ice
 Other _____

Please Check all of the following tests/treatments you have had for this condition & dates performed:

X-ray _____
 MRI _____
 CT Scan _____
 EMG _____

Blood Work _____
 Physical Therapy _____
 Injection _____
 Chiropractic Manipulation _____

Please list your goals & expectations from having treatment with us: _____

Prior Surgeries & Hospitalizations (list type of surgery or reason for hospitalization & approx year of event)

_____- _____ - _____
_____- _____ - _____
_____- _____ - _____

Have you ever been involved or injured in auto accident(s), falls, sports injuries & approx year of occurrence

_____- _____ - _____
_____- _____ - _____
_____- _____ - _____

Please circle if you have/had any of the following:

Heart problems Bronchitis
Heart attack/failure Emphysema
Heart Surgery Stomach ulcers
Pacemaker Heartburn/GERD/reflux
High Blood Pressure Irritable bowel syndrome
Anemia Spinal cord injury
Asthma Diabetes
Cancer _____

Thyroid disease Stroke
Kidney problems Seizures
Glaucoma Multiple Sclerosis
Rheumatoid arthritis Parkinson's disease
Osteoarthritis Depression
Fracture/broken bones Anxiety
Fibromyalgia Pregnant
Other _____

Do you have history of drug or alcohol addiction or treatment for drug/alcohol use? _____

Please list any family history of diseases: _____

—————PLEASE COMPLETE NEXT PAGE—————

