

Patient Medical History

Name: _____ Date: _____
 What is your primary problem? _____
 Secondary problem? _____
 How did your problem begin? _____
 When did your problem begin? _____
 Have you ever had anything similar? Yes/No
 Please explain: _____
 What is your occupation? _____
 Are you working? Yes/No Is this work related? Yes/No
 Prior to your problem were you free of symptoms? Yes/No

Please describe your problem using the diagram to the right =>

What treatments, if any, have you had for this current problem? _____

Did they help? Yes/No
 What in particular makes your pain worse? _____

What eases your pain? _____

Can you get comfortable at night? Yes/No
 How do you feel upon rising? Stiff ___ Sore ___ Fine ___
 Once you start moving around, does it: Worsen? ___ Ease? ___
 What is it like at the end of the day? Worse? ___ Easier? ___
 Do you have any pins and needles? Yes/No
 Are you currently taking any prescription or non-prescription medications? Yes/No
 Anti-inflammatory ___ Muscle Relaxers ___ Pain Medication ___

List Medications: _____

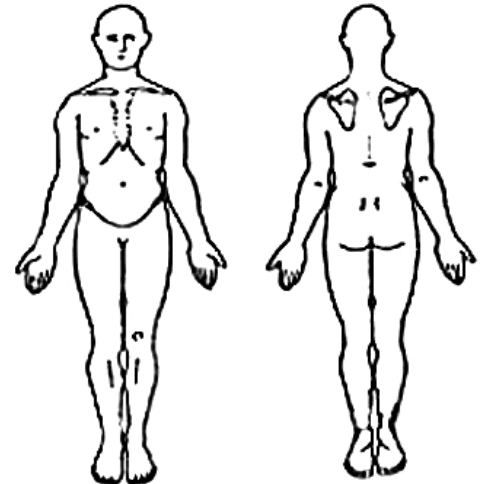
Are you allergic to any medications? Yes/No If yes, what: _____

At this time do you consider you are getting: Better ___ Worse ___ Stable ___

Have you had surgery for this injury? Yes/No If yes, how many? ___ Type _____

List any other information that would assist us in your care:

SITES OF PAIN



Do you now have or have you ever had ANY of the following?

	Yes	No		Yes	No
Asthma, Bronchitis, or Emphysema	___	___	Severe or Frequent Headaches	___	___
Shortness of Breath/Chest Pain	___	___	Vision or Hearing difficulties	___	___
Coronary Heart Disease or Angina	___	___	Numbness or Tingling	___	___
Do you have a Pacemaker	___	___	Dizziness or fainting	___	___
High Blood Pressure	___	___	Bowel or Bladder Problems	___	___
Heart Attack or Surgery	___	___	Weakness	___	___
Stroke/TIA	___	___	Weight Loss/Energy Loss	___	___
Congestive Heart Disease	___	___	Hernia	___	___
Blood Clot/Emboli	___	___	Varicose Veins	___	___
Epilepsy/Seizures	___	___	Allergies	___	___
Thyroid Disease or Goiter	___	___	Any Pins or metal implants	___	___
Anemia	___	___	Joint replacement surgery	___	___
Infectious Diseases	___	___	Neck Injury/Surgery	___	___
Diabetes	___	___	Shoulder Injury/Surgery	___	___
Cancer or Chemotherapy/Radiation	___	___	Elbow/Hand injury/surgery	___	___
Arthritis	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Gout	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Sleeping Problems/Difficulties	___	___	Are you pregnant?	___	___
Emotional/Psychological Problems	___	___	Do you use tobacco?	___	___