Patient History Form

Date: ________________

Patient Information

Name ____ DOB __________________ Sex *M* *F*

Address _________________________________ City _____________________ State ___ Zip _________

Cell Phone ______________________________ Email ____

Employer/Occupation ________________________________ Referred Here by ____________________

Emergency Contact ____

Phone ____________________________________ Relationship _________________________________

Insurance Information

Ins Co ___________________ Member ID ____________________________ Group # ______________

Policy Holder ____ DOB ________________________

Employer _____________________________________ Relationship to Patient ____________________

2ndary Insurance Information

Ins Co ___________________ Member ID ____________________________ Group # ______________

Policy Holder ____ DOB ________________________

Employer _____________________________________ Relationship to Patient ____________________

Patient Condition

Reason for visit ____

When did symptoms appear? __________________ Is condition progressively worsening? *Yes* *No*

Mark an X on the picture where you continue to have pain, numbness or tingling.

Rate the severity of your pain from 1(least) to 10 (severe) _________

Is your pain: *constant* *comes & goes*

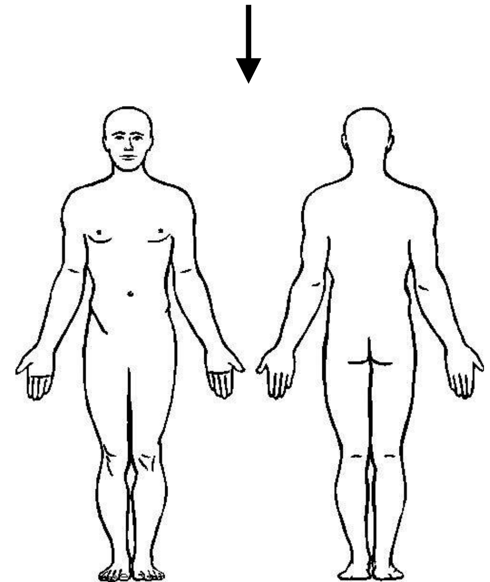
How often do you have this pain? ______________________________

Type of pain: *sharp* *dull* *throbbing* *numbness* *aching* *shooting* *burning* *tinging* *cramps* *stiffness* *swelling* *other* ________________

Does your pain interfere with: *work* *sleep* *daily routine* *recreation* *N/A*

Activities or movements that are painful to perform:

sitting *standing* *walking* *bending* *lying down*



Accident Information **N/A**

Type of Accident: *auto* *work* *home* *other*__________________________ Date: ______________________

Have you reported you accident to: *Auto Ins* *Employer* *Worker's Comp* *Other*____________________________

Health History

What treatment have you already received for your condition?

medication *physical therapy* *chiropractic* *surgery* *none* *other:* ____

Name of other practitioner(s) whom have treated your condition: ____

Date of Last: Physical ___________________ Spinal X-Ray ________________ Blood Test _____________________

Chest X-Ray ___________________________ Spinal Exam ________________ Urine Test ______________________

Dental X-Ray __________________________ MRI, CT Scan, Bone Scan ____________________________________

Indicate if you have had any of the following:

AIDS/HIV	*Chicken Pox*	*Liver Disease*	*Rheumatoid Arthritis*
Alcoholism	*Diabetes*	*Measles*	*Rheumatic Fever*
Allergy Shots	*Emphysema*	*Migraines*	*Scarlet Fever*
Anemia	*Epilepsy*	*Miscarriage*	*Stroke*
Anorexia	*Fractures*	*Mononucleosis*	*Suicide Attempt*
Appendicitis	*Glaucoma*	*Multiple Sclerosis*	*Thyroid Problems*
Arthritis	*Goiter*	*Mumps*	*Tonsilitis*
Asthma	*Gonorrhea*	*Osteoporosis*	*Tuberculosis*
Bleeding Disorders	*Gout*	*Pacemaker*	*Tumors, Growths*
Breast Lump	*Heart Disease*	*Parkinson's*	*Typhoid Fever*
Bronchitis	*Hepatitis*	*Pinched Nerve*	*Ulcers*
Bulimia	*Hernia*	*Pneumonia*	*Vaginal Infections*
Cancer	*Herniated Disk*	*Polio*	*Venereal Disease*
Cataracts	*Herpes*	*Prostate Problems*	*Whooping Cough*
Chemical Dependency	*High Cholesterol*	*Prosthesis*	*Other:* _______________
	Kidney Disease	*Psychiatric Care*	______________________

Allergies ____ **Current Pregnancy? No Yes Due Date:** ______________

Exercise: *None* *Moderate* *Daily* *Heavy* **Work Activity:** *Sitting* *Standing* *Light Labor* *Heavy Labor*

Habits: *Smoking - Packs/Day* _________ *Alcohol - Drinks/Week* ________ *Caffeine Drinks - Cups/Day* __________
High Stress Level - Reason ____

Social Determinants of Health: Are you struggling with basic needs such as food, housing, safety, etc? Yes No

Injuries/Surgeries **Description** **Date**

Falls ____

Head Injuries ____

Broken Bones ____

Dislocations ____

Surgeries ____

Medications ____

Vitamins/Herbs/MInerals ____