Patient Health History

Name _____ Age_____ Height_____ Weight_____ Gender_____ Date _____/_____/_____

CC: What is the reason for today's visit?

HPI: Are you currently experiencing discomfort? ❒ Yes ❒ No | Is this the first time for these symptoms? ❒ Yes ❒ No

When did your symptoms begin most recently? | When did you first experience these symptoms?

How did your symptoms start? (Check all appropriate boxes) ❒ Suddenly ❒ Gradual onset ❒ Auto injury ❒ Work injury ❒ Other

Describe details of any event leading to this problem (date, what happened)

What are you unable to do now that you could do before this problem began?

How long do your symptoms last? | Are your symptoms ❒ constant or ❒ intermittent?

Is your condition getting: ❒ Better ❒ Worse ❒ No Change ❒ Unsure

Indicate the impact of the following activities on your problem. Leave blank all that do not apply. **B**etter **W**orse **S**ame/No Change

	B	W	S		B	W	S		B	W	S		B	W	S
Ice	❒	❒	❒	Yoga/Pilates	❒	❒	❒	Lying, knees up	❒	❒	❒	Orthotics/Lifts/Braces	❒	❒	❒
Heat	❒	❒	❒	Stretching	❒	❒	❒	Lying, knees down	❒	❒	❒	Injections	❒	❒	❒
Standing	❒	❒	❒	Exercise	❒	❒	❒	Bending forward	❒	❒	❒	Physical Therapy	❒	❒	❒
Sitting	❒	❒	❒	Massage	❒	❒	❒	Bending backward	❒	❒	❒	Chiropractic	❒	❒	❒
Walking	❒	❒	❒	Meditation	❒	❒	❒	Deep breathing	❒	❒	❒	Acupuncture	❒	❒	❒
Twisting	❒	❒	❒	Rest/ Sleep	❒	❒	❒	Coughing	❒	❒	❒	Medication	❒	❒	❒
Sneezing	❒	❒	❒		❒	❒	❒	Working on computer	❒	❒	❒		❒	❒	❒

Have you been hospitalized for this problem? ❒ Yes ❒ No | Number of times | Dates

Check the diagnostic procedures you have had as a result of this problem? ❒ X-ray ❒ CT scan ❒ MRI ❒ Lab Work ❒ Bone Densitometry ❒ Range of Motion Studies ❒ Electromyogram (EMG) ❒ Nerve Conduction Study

Other Providers - What other Healthcare Providers have you seen for this condition?

Healthcare Provider	Dates	Healthcare Provider	Dates
1.		3.	
2.		4.	

REVIEW OF RECENT SYMPTOMS

General ❒ fatigue
❒ difficulties sleeping
❒ waking up not refreshed
❒ fevers or chills
❒ weight/appetite change
❒ night sweats
❒ anxious/worry a lot

Cardiovascular
❒ tightness in chest
❒ swelling
❒ blood clot(s)
❒ leg cramps (walking)
❒ color change in fingers

Respiratory
❒ cough
❒ frequent respiratory infections
❒ shortness of breath
❒ wheezing

Gastrointestinal
❒ diarrhea
❒ constipation
❒ nausea
❒ vomiting
❒ black or bloody stools

Skin
❒ rashes ❒ hair loss
❒ recent bruising
❒ skin changes

Musculoskeletal
❒ weakness
❒ muscle aches
❒ restless legs at night
❒ stiffness of joints
❒ swollen or inflamed joints
❒ dropping things
❒ morning stiffness
❒ difficulty walking

Ears, Nose and Throat
❒ jaw problems
❒ ear pain
❒ hearing loss
❒ ringing in your ears
❒ frequent sore throats
❒ sinus problems

Neurological
❒ numbness
❒ tingling
❒ dizziness
❒ spinning sensation
❒ radiating pain
❒ headache
❒ weakness
❒ memory problems
❒ concentration problems

Eyes
❒ eye pain
❒ change in vision
❒ discomfort with bright lights

Patient Health History

MEDICAL HISTORY of ILLNESS/DISEASE (Ongoing or past medical conditions.)

S= Self F= Family	S	F	S= Self F= Family	S	F	S= Self F= Family	S	F	S= Self F= Family	S	F
Alcoholism	❒	❒	Depression	❒	❒	Irritable Bowel	❒	❒	Restless Leg Syndrome	❒	❒
Anemia/ Bleeding Disorders	❒	❒	Diabetes Mellitus	❒	❒	Joint Replacement	❒	❒	Rheumatoid Arthritis	❒	❒
Ankylosing Spondylitis	❒	❒	Endometriosis	❒	❒	Kidney Disease	❒	❒	RSD/CRPS	❒	❒
Anxiety/Panic Disorder	❒	❒	Environmental Allergy	❒	❒	Liver Disease	❒	❒	Scoliosis	❒	❒
Asthma	❒	❒	Epilepsy/Seizures	❒	❒	Meniere's Disease	❒	❒	SLE/Lupus	❒	❒
Bell's Palsy	❒	❒	Fibromyalgia	❒	❒	Multiple Sclerosis	❒	❒	Sleep Apnea	❒	❒
Cancer	❒	❒	Food Allergies	❒	❒	Obesity	❒	❒	Suicide Attempt	❒	❒
Carpal Tunnel Syndrome	❒	❒	Gout	❒	❒	Osteoarthritis	❒	❒	TMJ problems	❒	❒
Chemical Dependency	❒	❒	Headaches	❒	❒	Osteoporosis	❒	❒	Tendonitis	❒	❒
Chronic Fatigue	❒	❒	Heart Disease	❒	❒	Psoriasis	❒	❒	Thyroid Disease	❒	❒
Chronic Sinusitis/Rhinitis	❒	❒	High Cholesterol	❒	❒	Post-Traumatic Stress	❒	❒	Traumatic Brain Injury	❒	❒
COPD/Emphysema	❒	❒	HIV/AIDS	❒	❒	Radiculopathy	❒	❒	Trigeminal Neuralgia	❒	❒
Crohn's Disease	❒	❒	Hypertension	❒	❒	Raynaud's Disease	❒	❒	Ulcerative Colitis	❒	❒
	❒	❒	Insomnia	❒	❒		❒	❒		❒	❒

SURGICAL HISTORY - Have you had surgery for this **or any other condition**? If so, please list them below

Surgery	Date	Surgery	Date	Surgery	Date
1.		3.		5.	
2.		4.		6.	

MEDICATIONS Please list all medications including dose and number of times taken per day
Include prescriptions, over the counter medications, vitamins, supplements, etc.

Medication	Strength	How often	4.	Strength	How often	Medication	Strength	How often
1.			5			7.		
2.			6.			8.		
3.			6.			9.		

ALLERGIES Please list any allergies to medications.

1.	2.	3.

TRAUMA HISTORY

Motor vehicle accident(s)?	❒Yes ❒No	Age	Any significant Falls? (ladder, horses, ice)	❒Yes ❒No	Age
Concussions or loss of consciousness?	❒Yes ❒No	Age	Physical, emotional, sexual abuse?	❒Yes ❒No	Age
Complications while giving birth?	❒Yes ❒No	Age	Are you currently living in an abusive situation?	❒Yes ❒No	Age
Any recent stressful events in your life?	❒Yes ❒No	Age			

SOCIAL HISTORY

Relationship status: ❒ single ❒ married ❒ divorced ❒ separated ❒ partnered ❒ widowed | Is your home life satisfying? ❒ Yes ❒ No

What type of work do you do? | Do you enjoy your work? ❒ Yes ❒ No ❒ both

Physical requirements/ergonomics at work: ❒ computer/desk work ❒ lifting if so, how many pounds? _____
❒ frequent sitting ❒ frequent bending ❒ repetitive motion ❒ driving if so, how many hours daily?

Education completed: ❒ grade school ❒ junior high ❒ high school ❒ college ❒ graduate school

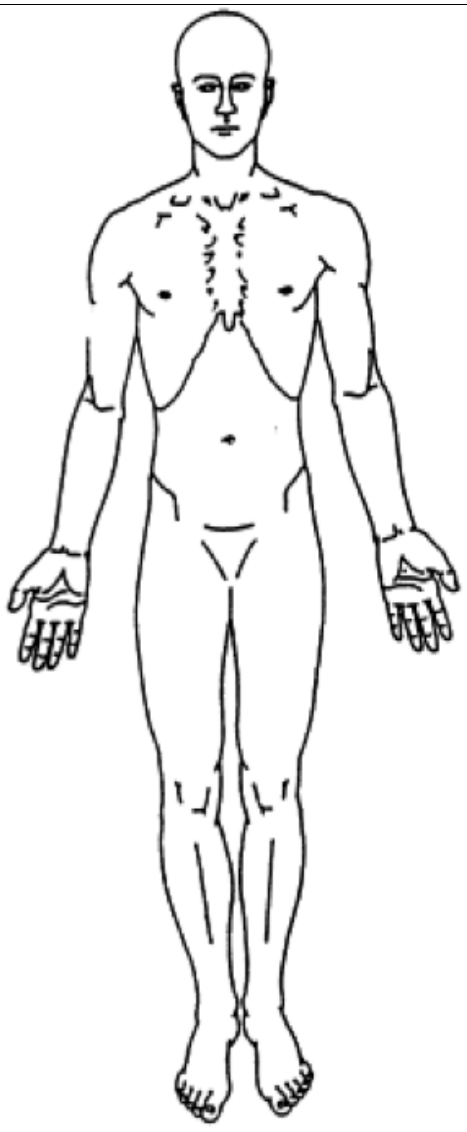
Habits	Amount	Per Day/Month	When Quit (if ever)	
Tobacco				
Alcohol				
Caffeine				
Other drugs				

BASIC HEALTH HABITS Fluid intake | Type/amount daily

	Maintain Weight with 10% of recommended	❒ Yes ❒ No		7-8 hours of sleep each night.	❒ Yes ❒ No
	Breakfast every day	❒ Yes ❒ No		Three meals a day	❒ Yes ❒ No
	Vigorous Physical Activity 3-4 times a week	❒ Yes ❒ No	Type of Activity?		
	Hobbies/Recreation	❒ Yes ❒ No	Type/frequency?		

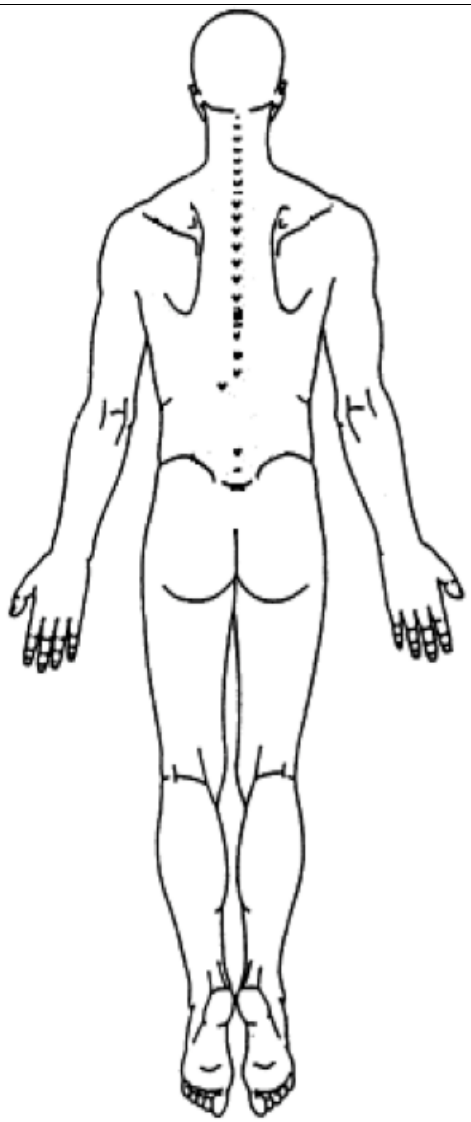
Patient Health History

Place an "X" thru the number that most closely describes **the most discomfort** you have had **this week**.										
No discomfort										Severe discomfort
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Circle the number that most closely describes **the least discomfort** you have had **this week.**										
No discomfort										Severe discomfort
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**



On the diagrams, use the symbols below to indicate the type and location of your discomfort.

Numbness	= = = = = =
Pins and needles	o o o o o o
Burning	X X X X X
Stabbing	/ / / / / / /
Ache	v v v v v



Thank you for providing this important information regarding your health and well-being.