Patient History Form

NAME: _____ **DATE OF BIRTH:** ___/___/___ **AGE:**____ **GENDER:** ____ **DATE:** ___/___/____

1. Marital Status: _____ **2.** Ages of Children _____

3. Who referred you to our clinic? _____

HISTORY OF PRESENT ILLNESS

4. Condition seeking help for today: _____

5. Describe your symptoms: _____

_____

_____

_____

_____

6. Side of the body the condition occurs on: NA / Right / Left / Both **7.** Condition Onset Date: ___/___/____

8. This condition: is chronic / is a new injury / occurred for no apparent reason

9. Is this condition related to an accident or a fall? Or can you relate it to any one incident?

_____

10. Have you had any diagnostic imaging for this condition? (MRI, Xray, etc)

_____

11. What types of doctors/clinicians have you seen for this condition? What treatments have you had for this condition? _____

_____

_____

12. Have you had physical therapy for this condition? _____

13. Have you had surgery for this condition? No / Yes: _____

14. What types of everyday, work, or recreational activities are you having trouble doing because of your symptoms?

_____

15. Are your symptoms constant? No / Yes

16. Your symptoms are: Getting better / Getting worse / Staying the same

Patient History Form

17. Circle activities that make symptoms worse.

Bending / Sitting / Turning / Rising / Standing / Walking / Lying / In the AM / As the day progresses /

In the PM / When still / When moving / Other: _____

18. Circle activities that make symptoms better.

Bending / Sitting / Turning / Rising / Standing / Walking / Lying / In the AM / As the day progresses /

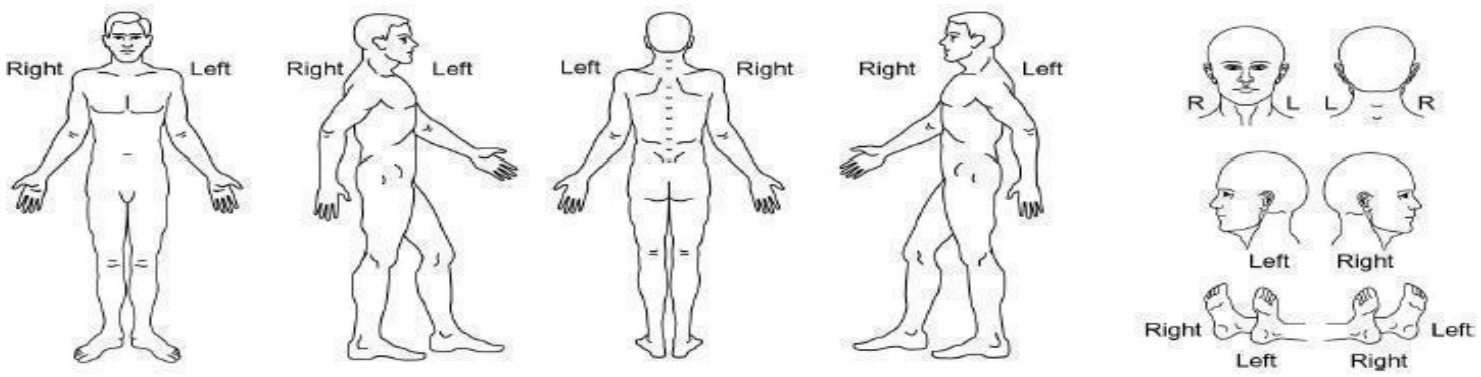
In the PM / When still / When moving / Other: _____

19. Circle the worst intensity of your symptoms in the past week: 0 1 2 3 4 5 6 7 8 9 10

20. Circle the current intensity your symptoms: 0 1 2 3 4 5 6 7 8 9 10

21. Circle the best intensity your symptoms were in the past week: 0 1 2 3 4 5 6 7 8 9 10

22. Shade or mark the areas where you experience your symptoms.



PAST MEDICAL HISTORY

23. Rate your general health: Good / Fair / Poor **24.** Living situation: Alone/Family/Other: _____

25. Occupation / Hobbies: _____

26. Have you fallen in the past year? No / Yes **27.** Do you fall often? No / Yes

28. CIRCLE ALL THAT APPLY TO YOU

Allergies	Gout	Recent Unintentional Weight Loss
Anxiety	Fracture	Short of Breath/Asthma
Arthrosclerosis	Headache	Smoker
Balance/Falls	Head Trauma	Stroke
Blood Pressure High/Low	Heart Attack	Swelling/Edema of Limbs
Blood Disease	Heart Disease	Thyroid Disease
Bowel/Bladder	Hepatitis	Tinnitus/ringing in the ear

Patient History Form

Cancer	Hernia	Tumor/Growth
Car Accident	Hearing Difficulties	Urinary Incontinence
Cholesterol	HIV/AIDS	Vision Trouble
Chronic Constipation/Diarrhea	Memory Difficulties	Other Cardiorespiratory
Depression	Osteoarthritis	Other Kidney/Urinary
Diabetes	Osteoporosis	Other Liver/Pancreas
Difficulty Sleeping	Currently Pregnant	Other Psychological
Drug Addiction	Past Pregnancies	Other Reproductive
Endometriosis	Pelvic Pain	Other Gastrointestinal
Epilepsy/Seizure	Radiation Treatments	Other Endocrine/Hormonal
Faint/Dizzy/Vertigo	Rheumatoid Arthritis	Other Neurological

29. List and date all surgeries you have undergone:

_____

_____

30. List and date all hospitalizations you have had:

_____

_____

31. Comments regarding past medical history:

_____

_____

32. Current Medications: (Indicate the type, dosage, purpose, and frequency taken.) _____

_____

33. Other comments regarding any of the above information or anything else you would like for us to know.

_____

_____

_____

34. I certify that this is accurate and complete to the best of my knowledge.

Signature: _____ **Date: ____/____/____**

*Please have guardian co-sign if patient is under 18.