

# PATIENT HISTORY

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_  
Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
Email \_\_\_\_\_  
Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Family Medical Doctor? \_\_\_\_\_  
Who may we thank for referring you to this office? \_\_\_\_\_

**WHAT BRINGS YOU TO OUR OFFICE?** Please provide as much detail as possible.

PRIMARY COMPLAINT: \_\_\_\_\_

Date when symptom first appeared \_\_\_\_\_ Did it begin:  Gradual  Sudden  Progressive over time

What makes the symptoms increase? \_\_\_\_\_ What relieves the symptoms? \_\_\_\_\_

Type of Pain:  Sharp  Dull  Ache  Burn  Throb Does the Pain Radiate into your:  Arm  Leg  Does not radiate

Do you have Numbness or Tingling?  yes  no How often do you experience these symptoms?  100%  75%  50%  25%  10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) \_\_\_\_\_

Please list all previous treatments for this condition (give doctor's name and dates if possible) \_\_\_\_\_

Do you have any family members who suffer from the same complaint? If so, who? \_\_\_\_\_

SECONDARY COMPLAINT: \_\_\_\_\_

Date when symptom first appeared \_\_\_\_\_ Did it begin:  Gradual  Sudden  Progressive over time

What makes the symptoms increase? \_\_\_\_\_ What relieves the symptoms? \_\_\_\_\_

Type of Pain:  Sharp  Dull  Ache  Burn  Throb Does the Pain Radiate into your:  Arm  Leg  Does not radiate

Do you have Numbness or Tingling?  yes  no How often do you experience these symptoms?  100%  75%  50%  25%  10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) \_\_\_\_\_

Please list all previous treatments for this condition (give doctor's name and dates if possible) \_\_\_\_\_

Do you smoke?  yes  no If yes, how many packs per week? \_\_\_\_\_

Have you ever smoked in the past?  yes  no If yes, when did you quit? \_\_\_\_\_

Do you take birth control?  yes  no Have you ever taken birth control in the past?  yes  no

Do you consume alcohol?  yes  no If yes, how many drinks per week? \_\_\_\_\_

Do you consume caffeine?  yes  no If yes, how many drinks per day? \_\_\_\_\_

Do you exercise?  yes  no If yes, how many times per week and what type? \_\_\_\_\_

Do you have a high stress level?  yes  no If yes, list reasons: \_\_\_\_\_

Please list any medications or vitamins you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

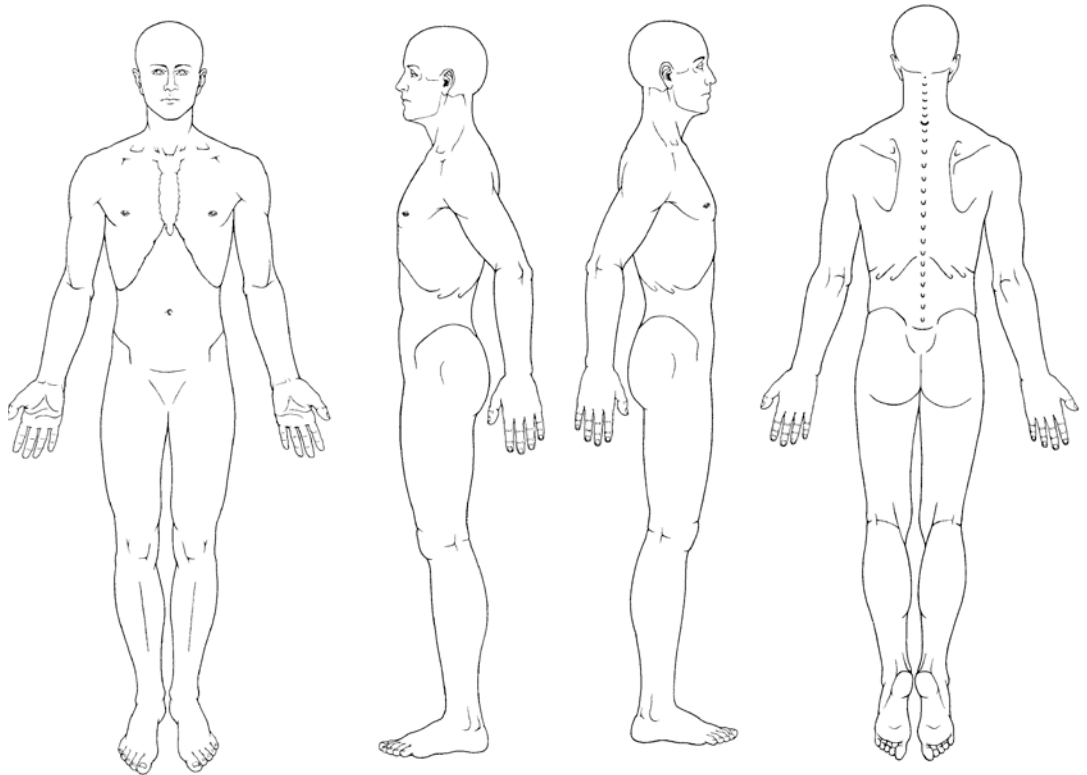
\_\_\_\_\_

\_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Please mark off the areas of your complaint on the diagram above with the following indicators:

- PPP = pain
- NNN = numbness
- TTT = tingling
- BBB = burning
- CCC = cramping
- XXX = other



Please list all surgeries, injuries, accidents, falls, etc: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please check if you have had any of the following:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anemia	<input type="checkbox"/> Allergy Shots	<input type="checkbox"/> Anorexia
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Disc Degeneration	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Gout
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Herpes
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Measles
<input type="checkbox"/> Migraine	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> MS	<input type="checkbox"/> Mumps
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Stroke
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tumors/Growths	<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Vascular Disease
<input type="checkbox"/> Vaginal Infections	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Other:				

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