Confidential Patient Health History

Name _____ Date ____/____/_____ Birth date ____/____/_____

Height _____ Weight_____ Gender_____

Do you smoke? (circle one): Every day. Some days. Used to smoke. Never smoked.

Medication Allergies: _____

Current Medications: _____

_____

HEALTH INFORMATION:

What is your Main Problem?_____

_____

How did condition begin? _____

Date problem began_____ Have you had this or similar conditions in the past?_____

What activities aggravate your condition? Excessive Sitting Excessive Standing Stress Walking

Running Exercise Bike Riding Daily Activities Bending House Cleaning Other - please explain

_____

Is this condition getting progressively worse? Yes No Constant Comes & goes Improving

Is this condition interfering with your: Work Sleep Daily routine Other

Other doctors who treated this condition _____

_____

Do you have any Secondary Problems? _____

_____

List surgical operations and year _____

_____

Are you wearing: Heel lifts Arch supports Braces or appliances _____

Have you been in an auto accident? Past five years Over five years Never

Have you ever had any other personal injury or accident: Past year Past five years Over five years

Describe _____

Circle any of the following conditions with which any of your immediate family members have been diagnosed:
Heart attack at age 35 or younger Heart attack at age 50 or younger Degenerative joint disease
Osteoporosis Cancer Autoimmune disease (such as M.S., rheumatoid arthritis, lupis)

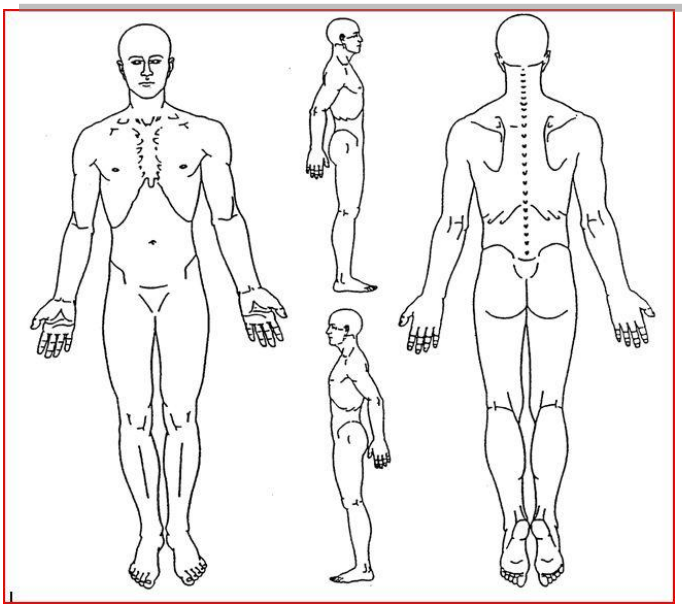
Primary Care Physician and Practice Name _____

Specialist Physicians Involved?_____

Date of last physical examination ___/___/____ Who performed the exam?_____

Mark the area(s) on the below figures where you feel the described sensations.
Use the appropriate symbols. Mark areas of referral or radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
…….	00000	XXXXX	^^^^^	/////



Neck – Shoulder – Arm Pain
On a scale of 0 to 10, I rate my discomfort as follows:
0=no pain 10=severe pain

Mid Back Pain
On a scale of 0 to 10, I rate my discomfort as follows:
0=no pain 10=severe pain

Low Back & Leg Pain
On a scale of 0 to 10, I rate my discomfort as follows:
0=no pain 10=severe pain

Please check all of the following that apply to you:

- ☐ Recent Fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke (Date)_____
- ☐ Corticosteroid Use (cortisone, prednisone, etc.)
- ☐ Dizziness/Fainting
- ☐ Numbness in Groin/Buttocks
- ☐ Cancer/Tumor (explain)_____
- ☐ Osteoporoses
- ☐ Epilepsy/Seizures
- ☐ Bladder/Bowel Control Problems
- ☐ Blood in Urine
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Currently Pregnant, #weeks _____
- ☐ Abnormal Weight Gain Loss
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Visual Disturbances
- ☐ Other Health Problems (explain)

_____
_____

Print Name _____

Patient Signature_____ Date_____

Signature of Person Assisting Form Completion _____