HEALTH HISTORY

Patient Name: _____ Age: _____ DOB: _____

Date of Onset/Injury: _____ Current Occupation: _____

Please circle your dominant hand (IE: the hand you write with): Right Hand or Left Hand

Please briefly describe how your symptoms started:

_____
_____
_____

Pain: Please rate your current pain (0 = No Pain and 10 = Worst Pain of Your Life)

☺ **0 1 2 3 4 5 6 7 8 9 10** ☹

Where is your pain located? _____ Right _____ Left_____ Bilateral ____

How would you describe your pain? (Circle all that apply)
Throbbing Stabbing Sharp Dull Constant Occasional Pins & Needles

Things that make your pain better? _____

Things that make your pain worse? _____

Do you have any of the following?

Pain that wakes you up from sleep? Yes _____ No_____

Numbness/Tingling in your hands? Yes _____ No_____

Weakness in your hands? Yes _____ No_____

Can you perform your Activities of Daily Living? (IE: getting dressed or brushing teeth) Yes _____ No_____

If No, please explain_____

Can you do your job? Yes _____ No_____

If No, please explain_____

REVIEW OF SYMPTOMS: Mark next to ANY current symptom.

_____Fever/Chills	**_____Nausea**	**_____Headaches**	**_____Breathing Problems**
_____Chest Pain	**_____Sore Throat**	**_____Constipation**	**_____Urination Problems**
_____Rashes	**_____Blurred Vision**	**_____ Other: _____**	

*****PLEASE CONTINUE TO PAGE 2*****

Have you ever been diagnosed with an antibiotic resistant infection? (IE: MRSA) Yes_____ No_____

Are you or could you be pregnant? Yes_____ No_____

Height: _____ Weight:_____ Age:_____

MEDICAL HISTORY:

_____Heart Problems _____Osteoporosis _____Diabetes _____Thyroid Disorder
_____Lung Problems _____Seizures _____Stomach Ulcers _____Rheumatoid Arthritis
_____Kidney Problems _____Blood Clots _____Hepatitis C _____HIV/AIDS
_____High Blood Pressure _____Stroke _____Other:_____

SURGICAL HISTORY: Previous Surgeries? Yes_____ No_____ If Yes, please list:

_____

_____

MEDICATIONS: Do you take any medications? Yes_____ No_____ If Yes, please list:

_____

_____

PAIN CONTRACT: Are you under a pain contract with another physician? Yes___ No___ If yes, please list:
Physician Name: _____ Clinic Name: _____

ALLERGIES: Do you have any allergies to medications? Yes_____ No_____ If Yes, please list medication(s) with associated reaction(s).

_____

_____

FAMILY HISTORY: Please list any medical conditions that run in your immediate family:

_____

_____

SOCIAL HISTORY:

Do you drink alcohol? Yes_____ No_____
Do you use tobacco products? Yes_____ No_____

X_____
Patient/Legal Guardian Signature Date