

PATIENT HISTORY FORM

(If seen within one year, list changes.)

NAME (print):		Date:	
D.O.B.:	Age:	S.S.#:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
Referred by: <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Attorney <input type="checkbox"/> Other Health Professional			
Primary Care Physician/Family doctor:			
Please describe the reason for your visit/current complaint:			
Acute Injury/Illness – New: <input type="checkbox"/> Yes <input type="checkbox"/> No		Chronic Symptoms/Illness – Old: <input type="checkbox"/> Yes <input type="checkbox"/> No	
How did the symptoms begin? If sudden, describe onset:			
On a scale of 1-10 (10 being most severe) check # that best describes your pain: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10			
Approximate date symptoms began or date of injury:			
Resulting from: <input type="checkbox"/> Sports <input type="checkbox"/> Accident <input type="checkbox"/> Work Related <input type="checkbox"/> Involving Litigation			
Are symptoms: <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent <input type="checkbox"/> Worsening <input type="checkbox"/> Improving			
Check all that apply: <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Instability <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness/tingling			
What makes symptoms worse?			
What makes symptoms better?			
What previous or formal treatment have you had? (medications, therapy, surgery, injections)			
Were previous treatments helpful to any degree? If so what?			
Allergies (food or other environmental) – List			

PAST MEDICAL HISTORY

GENERAL	YES	NO	CARDIOVASCULAR	YES	NO
Are you currently pregnant?			Chest pain, Angina		
Diabetes			Heart Attack, Myocardial Infarction		
Stroke			Palpitations		
Kidney Disease			High Blood Pressure, Hypertension		
Ulcers			Shortness of Breath		
Asthma or Lung Disease			Ankle Swelling		
Cancer TYPE:			HEMATOLOGIC		
Fatigue			Anemia		
Fevers			Bleeding tendency		
Skin Problems/disorders TYPE:			Easily bruised		
Rheumatic Fever			Circulatory problems		
Tuberculosis			Blood thinners (currently on)		
Recent weight loss/gain. How much?			(If yes, type?)		
BLOOD-BORNE PATHOGENS			Phlebitis		
HIV/AIDS			MUSCULOSKELETAL		
Hepatitis			Joint Pain		
Other			Joint Swelling		
SITES OF INFECTION			Muscle weakness		
Urinary			Muscle tenderness		
Dental			Morning stiffness		
Other			Arthritis/Osteoarthritis		
NEUROLOGICAL			Rheumatoid Arthritis		
Headaches			Bunions		
Dizziness			Osteoporosis		
Fainting			Previous bone density test?		
Memory Loss			Bone/Joint infections		
Loss of consciousness			Gout		
Muscle spasms			PSYCHOLOGICAL		
Numbness or tingling of hands/feet			Depression		
Blindness or trouble seeing			Depression		
Deafness or trouble hearing			Other		
Seizures					
Other illnesses or diseases which are not listed? Please describe:					

