Patient History Form **Date:** ___________________________

Last Name_______________________________**First**________________________________**Middle**____________________

Birth Date____/____/_____ **Age:** _______ **Marital Status:** S M W D **Sex:** Male Female

Pregnant? Yes No Maybe (signature) ____ (date) __________________

How would you describe your chief complaint at this time?

____

When did it start? Date ___________________________ **Where is the pain located?** ____

How would you describe the pain? ______________________________________**What makes it worse?** ______________________________

Is the pain intermittent occasional frequent constant

How long did you have pain before you first sought treatment? _________________________
When did you have these or similar symptoms? _______________________________________

Is your pain the result of: Motor Vehicle Accident: Yes No **Job Injury:** Yes No **Personal Injury:** Yes No

If yes, please explain: ____

Current Medications: ____

Allergies: ____

Do you now or have you in the past had any of the following?

Weight loss/gain	Yes	No	Ear infections	Yes	No
Fever/chills	Yes	No	Tinnitus/ringing in ears	Yes	No
Allergies	Yes	No	Hepatitis	Yes	No
Anemia	Yes	No	Kidney or bladder infection	Yes	No
Diabetes	Yes	No	Kidney stones	Yes	No
Cancer	Yes	No	Joint pain	Yes	No
Thyroid disease	Yes	No	Back pain	Yes	No
Poor memory	Yes	No	Neck pain	Yes	No
Headaches	Yes	No	Muscle spasms	Yes	No
Epilepsy/convulsions	Yes	No	Weakness	Yes	No
Stroke	Yes	No	Rash/skin lesion	Yes	No
Vision problems	Yes	No	Hair/nail changes	Yes	No
Heart attack	Yes	No	Anxiety	Yes	No
Blood clots	Yes	No	Depression	Yes	No
High blood pressure	Yes	No	Numbness/tingling	Yes	No
Indigestion	Yes	No	Menstrual/prostate problems	Yes	No
Vomiting/Diarrhea	Yes	No	Other___________________		
Colon or bowel trouble	Yes	No	________________________		
Hemorrhoids	Yes	No	________________________		

Do you smoke? Yes No **If yes, how many packs per day** __________ **Do you drink alcohol?** Yes No **How much**___________

Family medical history (diabetes, cancer, heart disease)____

Past medical history (surgery, etc.)____

Other____

Reviewed by____________________________________ Date _________________

____________________________________ Date _________________