



# Health History

Name \_\_\_\_\_

Date \_\_\_\_\_

1. **What is the primary complaint you are being seen for? Please be specific and give a brief description.** \_\_\_\_\_  
\_\_\_\_\_
2. **When did this problem begin? (Date, approximate if unknown)** \_\_\_\_\_
3. **What type of problem is it?**
  - a. New injury
  - b. Previous injury
  - c. Auto injury
  - d. Workers compensation
  - e. Post-surgical, Date of surgery \_\_\_\_\_
  - f. Other
4. **Where did the problem occur?**
  - a. Work
  - b. Home
  - c. Motor vehicle accident
  - d. During recreation
  - e. Competitive sports
  - f. Other \_\_\_\_\_
5. **Have you had any treatment for this problem prior to today?**
  - a. None
  - b. Surgery
  - c. Chiropractic
  - d. Physical Therapy
  - e. Medication/Injections
  - f. Other \_\_\_\_\_
6. **Have you had any special tests for this problem?**
  - a. None
  - b. X-Rays
  - c. CT scan
  - d. MRI
  - e. EMG
  - f. Bone scan
  - g. Other \_\_\_\_\_
7. **Test Results (skip if no tests performed)** \_\_\_\_\_
8. **What is your employment status?**
  - a. Employed: Position (please write) \_\_\_\_\_ (Circle) Full time      Part time
  - b. Student
  - c. Unemployed
  - d. Retired
  - e. Homemaker
  - f. Disabled
9. **If employed do you have any restrictions at work?** \_\_\_\_\_
10. **What are your primary job tasks? (Circle all that apply)**
  - a. Prolonged sitting
  - b. Prolonged standing
  - c. Lifting
  - d. Repetitive tasks
  - e. Operating a machine
  - f. Driving
  - g. Other \_\_\_\_\_
11. **What are your exercise habits?**
  - a. None
  - b. Mild (stairs, short walk, golf)
  - c. Occasional (4x/week, less than 30 minutes)
  - d. Regular (4x/week, 30 minutes or more)
12. **Current symptom description (Circle all that apply)**  
Sharp pain   Dull pain   Burning   Tingling   Dizziness  
Nausea   Aching   Numbness   Constant   Intermittent  
Other \_\_\_\_\_
13. **Is your pain worse in the morning, at mid-day, or at night? (Circle answer)**

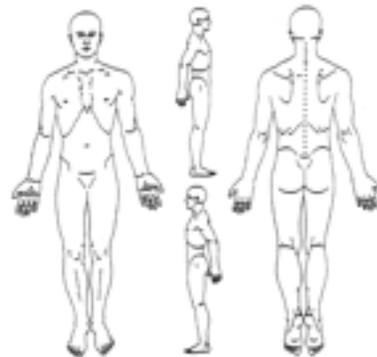
14. On a scale of 0-10 (0 being no pain, 10 being extreme pain) rate your pain (Circle the number)?



15. What affects your pain (see chart below)?

	Better	Worse	Same		Better	Worse	Same
Ice				Sleeping			
Heat				Lying down			
Sitting				Coughing/sneezing			
Standing				With activity			
Walking				After activity			
Rising from sitting				Rest			
Position changes							

16. Please mark the body chart with an X in the areas of pain.



17. Please list any surgeries you have had including implantations (i.e. IUD, pacemaker, pain pump, lap band, clips, mesh, staples, etc):

Date:

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18. Please circle any of the following health conditions that you have or had in the past.

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|-------------------------|----------------------------|-------------------|
| a. None                 | l. Unexplained weight loss | w. Tuberculosis   |
| b. Cancer               | m. Chemical dependency     | x. Kidney disease |
| c. Diabetes             | n. History of fracture     | y. Anemia         |
| d. High blood pressure  | o. Seizures                | z. Stroke         |
| e. Heart problems       | p. Currently pregnant      | aa. Osteoporosis  |
| f. Rheumatoid arthritis | q. # of pregnancies _____  | bb. Smoker        |
| g. Osteoarthritis       | r. # of deliveries _____   | cc. Menopausal    |
| h. Asthma               | s. Thyroid disease         | dd. Incontinence  |
| i. Emphysema            | t. Multiple sclerosis      | ee. Depression    |

j. Over weight  
k. Fibromyalgia

u. Hepatitis  
v. Allergies

ff. Mental Illness  
gg. Other \_\_\_\_\_

19. Please list ALL medications that you are taking and list the dosage. (Please be very specific.)  
Medication Dosage

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