Updated 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)**

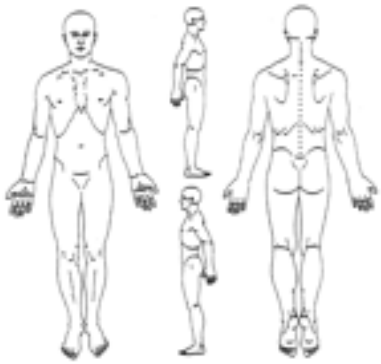
→

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:

_____-
_____
_____
_____
_____
_____

18. Are there any changes/updates to your medical history/diagnosis ___Yes ___No
If yes, please explain:

_____
_____
_____

19. Are there any changes in your medications/dosages? ___Yes ___No
If yes, please explain: