Patient History Form

Name:_____ Age:_____ DOB:_____ Date:_____

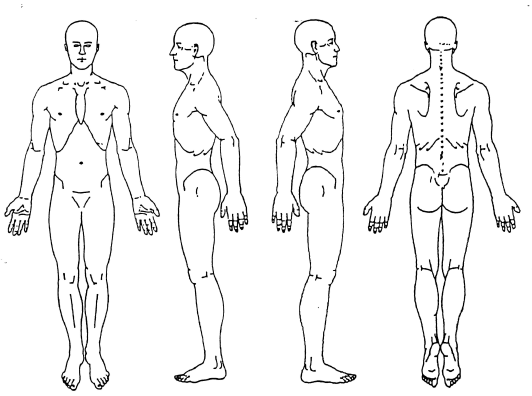
Occupation:_____

Chief Complaint: _____

Front / Left Side / Right Side /

Back

Please draw an arrow and label the area of injury or discomfort on chart.	Numbness……**N** Pins and Needles……..**P** Burning……**B** Aching……**A** Stabbing……...**S**

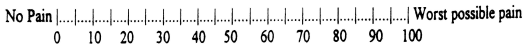


Date of injury:_____ Date symptoms appeared:_____

How did this occur?_____

What helps relieve pain?_____

What worsens pain?_____



Circle level of intensity

(check all that apply) Pain…

☐ travels ☐ is localized ☐ is mild ☐ is moderate ☐ is severe

☐ is constant ☐ is intermittent ☐ is constant with varying degrees of intensity

☐ occurs at home ☐ occurs at work ☐ occurs with exercise ☐ occurs in AM ☐ occurs in PM

☐ is better ☐ is same ☐ is worse

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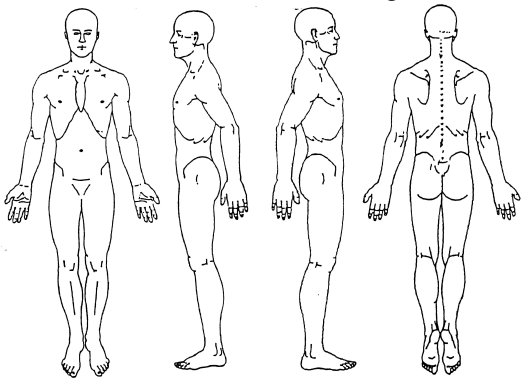
Secondary Complaint:_____

Front / Left Side / Right Side /

Back

Please draw an arrow and label the area of injury or discomfort on chart.	Numbness……**N** Pins and Needles……..**P** Burning……**B** Aching……**A** Stabbing……...**S**

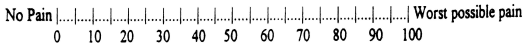


Date of injury:_____ Date symptoms appeared:_____

How did this occur?_____

What helps relieve pain?_____

What worsens pain?_____



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(check all that apply) Pain…

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 occurs at home occurs at work occurs with exercise occurs in AM occurs in PM

 is better is same is worse

Other complaints and their locations:_____

_____

_____

Exercise:	**Work Activity:**	**Habits**:	
____ None	____ Sitting	____ Smoking	____ Packs / Day
____ Moderate	____ Standing	____ Alcohol	____ Drinks / Week
____ Daily	____ Light Labor	____ Coffee / Caffeine Drinks	____ Cups / Day
____Heavy	____Heavy Labor	____High Stress level	

Injuries / Surgeries you have had:	**Description:**	**Date:**
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries:		
Scars:		

Medications: (prescription & OTC)	**Allergies:**	**Vitamins / Herbs / Minerals:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date:_____

Reviewed by:_____ Date:_____
(Doctor)

Additional Notes:

_____

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