

PAST HISTORY

Have you had similar pain in the past? YES NO When? _____

If so, Please explain _____

Have you been in any car accidents? YES NO If so, When? _____

Have had any bad falls? YES NO If so, When? _____

List any injuries from falls, accidents, head injuries, broken bones or dislocations? If you have had any, please state what part of your body the injury happened and when it happened. _____

HEALTH HISTORY – CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE HAD:

*AIDS/HIV *Alcoholism*Allergy Shots*Anemia*Anorexia*Appendicitis*Arthritis*Asthma*Bleeding Disorder
*Breast Lump*Bronchitis*Cataracts*Chemical Dependency*Chicken Pox*Diabetes*Depression*Emphysema
*Epilepsy*Fractures*Glaucoma*Goiter*Gout*Gonorrhea*Heart Disease*Hepatitis*Hernia*Herniated Disc
*High Cholesterol*High Blood Pressure*Pacemaker*Parkinson's Disease*Pinched Nerve*Pneumonia*Polio
*Prostrate Problems*Prosthesis*Psychiatric Care*Rheumatoid Arthritis*Scarlet Fever*Stroke*Suicide Attempt
*Thyroid Problems*Tonsillitis*Tuberculosis*Tumors or Growths*Typhoid Fever*Ulcers*Vaginal Infections
*Venereal Disease*Whooping Cough*Other _____

Have you had Cancer? YES NO If so, What kind and when? _____

List any illnesses that run in your family: _____

List any medications that you take and what you take them for: _____

List any surgeries that you have had and when you had them: _____

Are you pregnant or do you think you may be? YES NO Date of last period? _____

HABITS

Smoking Packs/Day _____
Alcohol Drinks/Week _____
Coffee Cups/Day _____
Soda Cans/Day _____
High Stress Level Reason _____

EXERCISE

None
Moderate
Daily
Heavy

WORK ACTIVITY

Sitting
Standing
Light Labor
Heavy Labor

AVERAGE HOURS WORKED PER WEEK _____

AGE _____ HEIGHT _____ WEIGHT _____ RACE _____

Signature _____

Date ____ / ____ / ____

SYMPTOMS

<u>LIST AREA OF PAIN</u>	<u>CIRCLE ONE</u>	<u>CIRCLE ONE</u>	<u>RATE PAIN</u>
#1 _____	Constant	Comes and Goes	Mild Moderate Severe 1 2 3 4 5 6 7 8 9 10
#2 _____	Constant	Comes and Goes	Mild Moderate Severe 1 2 3 4 5 6 7 8 9 10
#3 _____	Constant	Comes and Goes	Mild Moderate Severe 1 2 3 4 5 6 7 8 9 10

******Please answer the following questions regarding your MAJOR complaint.******

How long have you had the pain for? _____

How did the pain start? GRADUALLY or ALL OF A SUDDEN

What were you doing when the pain started? _____

Type of pain (circle all that apply): Sharp Dull Numbness Aching Shooting Burning

Stiffness Tightness Radiating with Numbness Tenderness Spasms Soreness Weakness

What activities are difficult to perform(Circle all that apply)? All Movement Bending Lifting
Walking Laying Down Sitting Standing

Is anything helpful for the pain? Heat Ice Rest Pain Relievers Exercise Other _____

Is your sleep affected? Hard to fall asleep or Pain wakes me

Is your pain worse in the: AM or PM

Have you already seen other doctors FOR THIS YOUR MAJOR COMPLAINT? Yes or No

If so, What and Where? X-Rays MRI Medication ER Surgery Physical Therapy

Chiropractic Care Other _____

Doctors who have treated you for your condition: _____

If so, where are they located? _____