



## Health History Form

Name: \_\_\_\_\_

Gender: Male Female      Handed: Right Left      Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Reason for Visit \_\_\_\_\_ Date: \_\_\_\_\_

### Today's Problem:

What part of your body is affected: Head Neck Arms Upper Back Lower Back Legs Other

Explain: \_\_\_\_\_

When did you start having this problem? \_\_\_\_\_

What does it feel like? \_\_\_\_\_

What activities affect this problem? \_\_\_\_\_

How severe is the discomfort? 1 2 3 4 5 6 7 8 9 10 (1 – Not Bad, 10 – Worst)

How long does it last? Seconds Minutes Hours Days

What makes it feel better? \_\_\_\_\_ Worse? \_\_\_\_\_

Does your problem involve a legal case? ..... YES NO

Does your problem involve a Workman's Compensation case? ..... YES NO

Does this problem relate to a Motor Vehicle Accident? ..... YES NO

### Treatment/Work Up to Date; Have you had the following:

EMG/Nerve Conduction Tests: N Yes (When: \_\_\_\_\_, by Whom: \_\_\_\_\_)

Epidural or Other Injections ("shots"): N Yes (When: \_\_\_\_\_, by Whom: \_\_\_\_\_)

Physical Therapy: N Yes (When: \_\_\_\_\_, Where: \_\_\_\_\_)

### Previous Surgeries – Spine – Brain – Heart – Other?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you being treated for, or have you been treated for, any of the following medical issues (circle):

High Blood Pressure      Stroke      Heart Attack      Lung Disease      COPD

Other: \_\_\_\_\_

**Review of Systems:** Signs and/or symptoms you may be experiencing or have experienced recently.

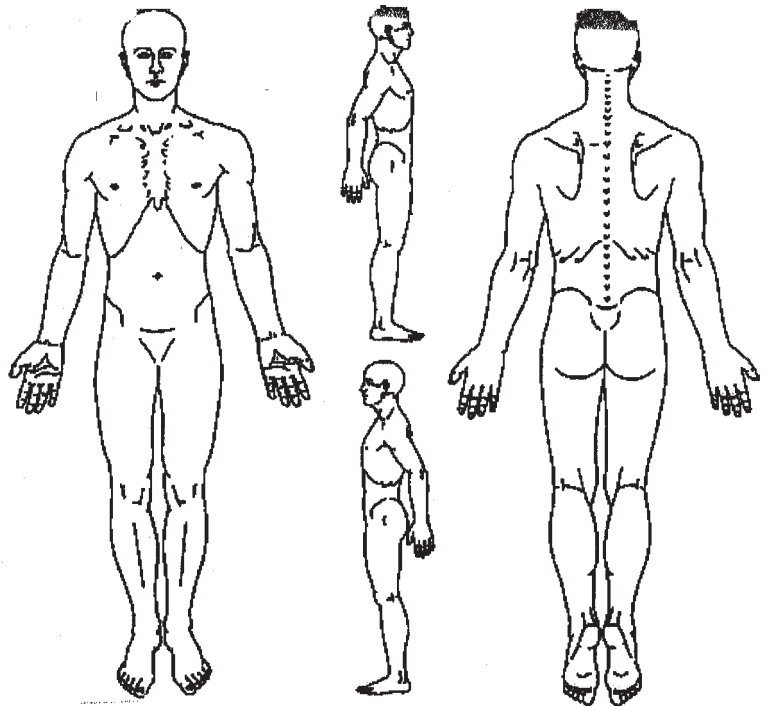
YES	NO		YES	NO		YES	NO	
___	___	Weight Loss	___	___	Lung Disease	___	___	Psychiatric
___	___	Fever	___	___	High Blood Pressure	___	___	Back Pain
___	___	Double Vision	___	___	Heart Disease	___	___	Neck Pain
___	___	Blurred Vision	___	___	Constipation	___	___	Arthritis
___	___	Hearing Loss	___	___	Diarrhea	___	___	Thyroid Problems
___	___	Dentures	___	___	Bowel Disease	___	___	Hepatitis
___	___	Difficulty Swallowing	___	___	Bladder Infections	___	___	Migraines
___	___	Sinusitis	___	___	Kidney Disease	___	___	Head Injury
___	___	Shortness of Breath	___	___	Ulcers	___	___	Stroke
___	___	Difficulty Breathing	___	___	Breast Lumps/Pain	___	___	Seizure/Epilepsy
___	___	Bronchitis	___	___	Anemia Blood Disease	___	___	Memory Loss
___	___	Asthma	___	___	AIDS	___	___	Diabetes
___	___	Pulmonary Embolus	___	___	Anxiety	___	___	Cancer
___	___	Hay Fever				___	___	Bleeding Tendencies

RIGHT
LEFT
LEFT
RIGHT

1. Please shade the drawings to indicate where you are experiencing your symptoms.

2. Next, label the areas you have shaded with the following letters where you feel them:

- A Ache
- B Burning
- C Cramping
- N Numbness
- P Pins and Needles
- S Stabbing
- E Electrical
- O Other



Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_