

Please Print

Confidential Health History

First Visit Date: _____

First

Last

MI

Name: _____ Home #: _____ Cell #: _____

Address: _____ City: _____ ZIP: _____

Email: _____ Date of Birth: _____ Age: _____ Sex: M F

Occupation: _____ Marital Status: _____ # Of Children: _____ Spouse's Name: _____

MAIN PROBLEM: Reason you are here. Be specific with location of pain. (If here only for **Wellness Skip to #12.**
Please note **Wellness** visits are not **covered by insurance**.): _____

1. When did it start? Approximate date: _____
2. How did it start? Explain: _____
3. Does the pain radiate to any other part of your body? Y N Where? _____
4. Describe your pain: (mild, moderate, severe) (dull, sharp, burning, numbness, soreness, stiffness) other: _____
(circle your answers)
5. Has it been getting better, worse, or about the same? Is it constant or does it come and go? _____
6. What makes your symptoms better? _____
7. What makes your symptoms worse? _____
8. What doctors have you seen and what tests have been done? _____
9. Have you had anything like this before? Explain: _____
10. Have you noticed any other changes in any body functions? _____
11. Has it affected your daily activities in any way? Work? _____
12. Do you have any other health problems that you would like me to evaluate? _____

PAST HISTORY:

1. Childhood diseases? Measles, rubella, chickenpox, mumps, scarlet fever, rheumatic fever, tuberculosis, mononucleosis, other: _____
2. Have you been diagnosed with any other conditions or under doctor's care for any type of problem? Explain: _____
3. Have you had any broken bones? Which ones? _____
4. Any auto accidents, work injuries or falls? When? _____
5. Any medications? Please list: _____
6. Any vitamins, herbs, etc. _____
7. Any type of surgery? What and when? _____
8. Any allergies? _____ How many times/year do you get sick? _____
9. Do any diseases run in your family? _____

LIFESTYLE

1. Describe your average/usual daily diet: (List foods you typically eat, drink, snacks, and times of day.)

Breakfast: _____

Lunch: _____

Dinner: _____

2. How many glasses of water/day? _____ What other beverages? _____

3. Describe your exercise/activity level: _____

DO YOU HAVE ANY OF THE FOLLOWING?

- Y N High blood pressure
- Y N Hardening of the arteries
- Y N Diabetes
- Y N Heart or blood vessel disease
- Y N Bone spurs on the neck
- Y N Whiplash injury
- Y N Any relatives ever suffer a stroke?
- Y N Blurred vision / Double vision
- Y N Do you currently smoke? How much? _____
- Y N Have you smoked in the past? When _____

ANY OF THESE SYMPTOMS, EVEN FOR A SHORT TIME, WITHIN THE LAST YEAR?

- Y N Slurred speech or other speech problems
- Y N Difficulty swallowing
- Y N Dizziness
- Y N Loss of consciousness or blackout
- Y N Numbness or loss of sensation in the face, arms, hands, fingers, legs or other part _____
- Y N Weakness, clumsiness, or loss of strength
- Y N Sudden collapse without loss of consciousness
- Y N Any loss of vision in one or both eyes
- Y N Hearing loss in one or both ears

WOMEN ONLY: Date of last period? _____

- Y N Birth control pills? How long? _____
- Y N Menstrual pain, cramping, or irregularity
- Y N Pregnant? How long? _____

MEN ONLY: Date of last prostate exam? _____

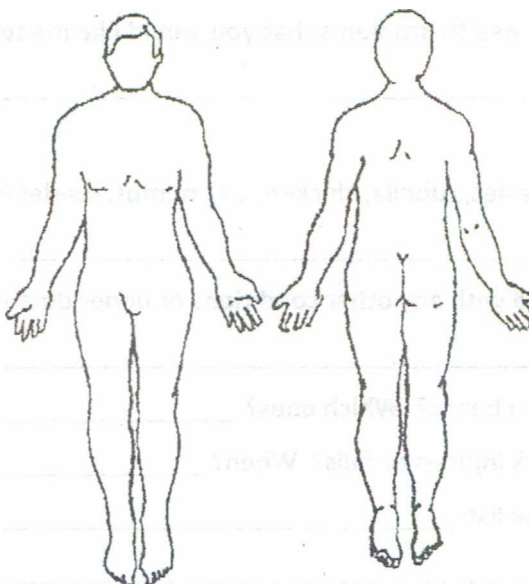
- Y N Difficulty or excessive urination?

On a scale of 1 to 10 place an X in your current pain level.

- NORMAL**
- () 0
- LOW PAIN**
- () 1
- () 2
- () 3
- MODERATE PAIN**
- () 4
- () 5
- () 6
- INTENSE PAIN**
- () 7
- () 8
- () 9
- EMERGENCY**
- () 10

RANSFORD PAIN DRAWING:

To help us better understand the nature and origin of your complaints we will ask that you carefully complete this drawing. Use the symbols listed below to detail where you hurt and how it hurts.



- //////// Dull Ache/Throb
- xxxxxxx Sharp/Stabbing
- BBBBBBBB Burning
- ===== Numbness
- Tingling
- SSSSSSSS Cramping

ATTENTION: Payment is to be made at the time of visit unless prior arrangements have been made with this office.

You will only be charged for services you consent to ahead of time.

Patient Signature: _____ Date: _____

For office use only

DX: 1. _____ 2. _____ 3. _____ 4. _____