Please Print

Confidential Health History

First Visit Date: ___________

First Last MI

Name: _______________________________________ Home #: _________________ Cell #: ___________________

Address: ____ 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: ___________________________________

____

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 ________

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? ___________________

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

MEN ONLY: Date of last prostate exam? _____________

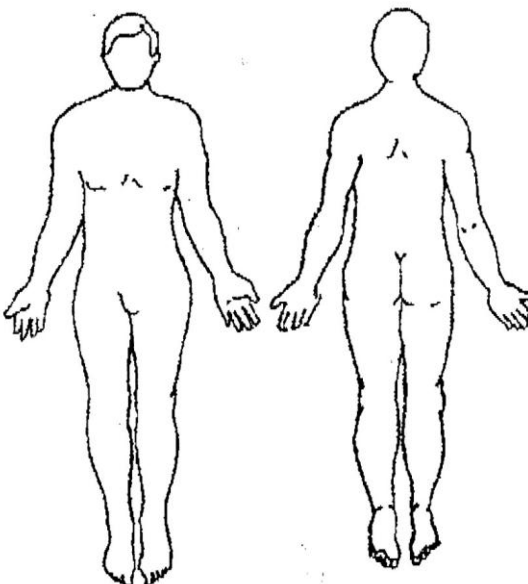
- Y N Difficulty or excessive urination?

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.



Symbol	Meaning
////////	Dull Ache/Throb
x x x x x x x	Sharp/Stabbing
BBBBBBBB	Burning
=========	Numbness
: : : : : : : : :	Tingling
SSSSSSSSS	Cramping

ATTENTION: Payment is to be made at the time of visit unless prior arrangements have been made with this office. Also a 24-hour notice is necessary to cancel an appointment, and you may be responsible for payment of a missed appointment.

I hereby consent to any procedures or treatments necessary for treatment of any condition as deemed reasonable by the attending doctor.

Patient Signature: ____ **Date:** ________________

For office use only

DX: 1. ____________ **2.** ____________ **3.** ____________ **4.** ____________