

Patient Medical History

Name _____ Age _____ Date of Birth ___/___/___ Date ___/___/___
 School (students only) _____ Who referred you? _____
 Personal Physician _____ Physician's Address _____

What is the main problem for which you are seeking medical attention? _____

When did this problem begin? _____ Is this problem a result of (circle one): MVA Sports Work Other

Please give details of how your pain/injury occurred: _____

What types of treatment have you tried for THIS problem?

	Dates	Please Describe
Surgery		
Chiropractic		
Physical Therapy		
Medication		
Other:		
Other:		

What diagnostic studies have been done for THIS problem?

	Dates	Results		Dates	Results
X-rays			MRI		
CT Scan			Bone Scan		
Other			Other		

On a scale of 1-10 (10=worst) how would you rate your pain? **(CIRCLE ONE)** 1 2 3 4 5 6 7 8 9 10

Is your pain getting **(CIRCLE ONE)**: Getting better Getting Worse Staying the Same

What makes your pain worse? _____

What makes your pain better? _____

How would you describe the nature or character of you pain? _____

Where is the majority of your pain located? _____

Does your pain or symptoms travel or radiate to other areas? If yes, describe: _____

Have you had the same or similar injuries/problems in the past? **No Yes** If "Yes", please describe: _____

Current Medications (including vitamins)	Allergies (describe reaction)

How much do you: Smoke: _____ packs/day _____ years
 drink caffeine: _____ cups/day
 drink alcohol: type _____ amount _____

Athletic / Sporting Activities		
	Amounts / Times per week	Previous Injuries
Sport 1:		
Sport 2:		
Sport 3:		

Please indicate both the location and nature of your pain on the diagram below. Please use the code:

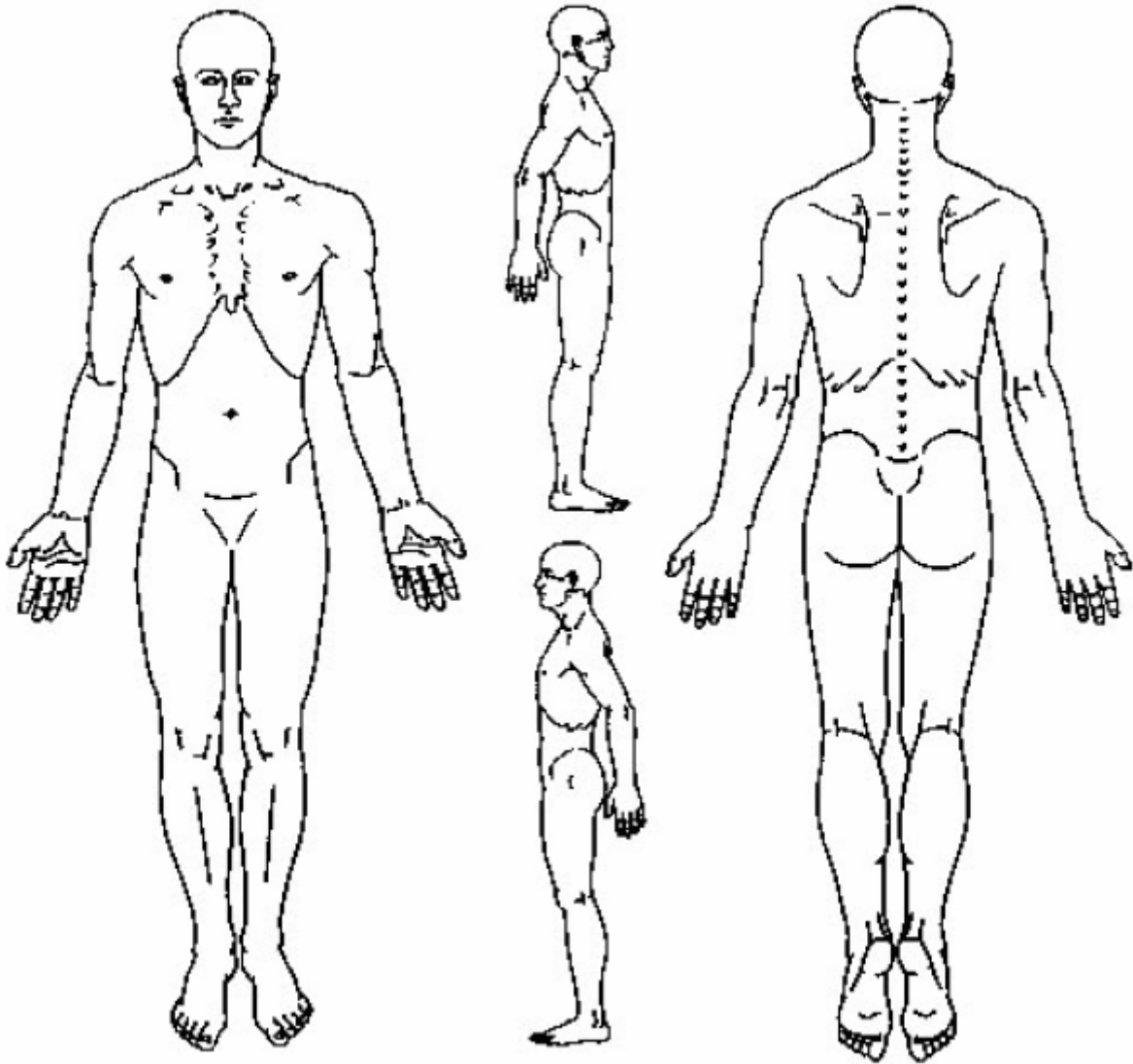
Numbness
===

Pins & Needles
ooo

Burning
XXX

Ache
^^^

Stabbing
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Family History

	If Living		If Deceased	
	Age	Health Problems	Age	Cause of Death / Health Problems
Father				
Mother				
Brother(s)				
Sister(s)				

Current Medical Problems (for which you are under treatment)	

Hospitalizations and Surgeries			
Date	Reason	Date	Reason

Medical History (please "O" all PRESENT conditions and "X" all PAST conditions):					
HEENT		RESPIRATORY		MUSCULOSKELETAL	
Headaches		Asthma		Herniated Disc	
Migraines		Bronchitis		Location:	
Concussion		Pneumonia		Broken bones	
Head injury		Short of breath w/ exercise		Specify:	
Eye problems		Coughing during / after exercise		Chronic back pain	
Wear glasses / contacts		Use an inhaler		Chronic neck pain	
Last eye exam:		GASTRO-INTESTINAL		Joint pain	
Hearing problems		Heartburn / indigestion		Specify:	
Sinus problems		Ulcers		Whiplash injury	
Frequent colds		Diarrhea		Shoulder injury	
CARDIOVASULAR		Constipation		Knee injury	
High blood pressure		Gall bladder problems		Sprained ankle	
Angina		Use antacids		Wear orthotics in shoes	
Chest pain with exertion		Hemorrhoids		Scoliosis	
Palpitations		Irritable bowel		Tendonitis	
Irregular heart beat		Colitis / Crohn's Disease		Bursitis	
Heart failure		Blood in stool/black tarry stool		Rheumatoid arthritis	
Get lightheaded/faint w/ exercise		Diverticulosis / Diverticulitis		Short leg	
Heart murmur		Excess gas / bloating		Osteoporosis	
High cholesterol		GENTOURINARY		ENDOCRINE	
Stroke		Frequent urinary infections		Diabetes (insulin-dependent)	
Aneurysm		Kidney stones		Diabetes (non-insulin dependent)	
Phlebitis / blood clots in legs		Prostate trouble (men only)		Hypothyroid (underactive)	
Varicose veins		Burning while urinating		Hyperthyroid (overactive)	
NEUROLOGICAL / PSYCHIATRIC		Incontinence		Gout	
		FEMALE ONLY		Easily fatigued	
Nerve injury Specify:		Age menopause:		OTHER	
		Age first menstrual period:		Anemia	
Anxiety		Frequency of periods:		Cancer	
Depression		Irregular menstrual cycles		Type:	
Panic attacks		Irregular bleeding / spotting		List:	
Dizziness		Frequent yeast infections			
Convulsions / seizures		# of pregnancies			
Anorexia / Bulimia		# of delivers			