



Name: _____

Visit Date: _____

DOB: _____ Age: _____

Height: _____ Weight: _____

Sex: Male / Female Handedness: Left / Right

Primary Care Physician: _____

Referring Physician: _____

SYMPTOMS: Please circle all that apply

Back Pain Neck Pain Arm Pain Leg Pain Joint Pain
Other: _____

The pain has been present for:

- 0 - 1 week 3 - 6 months
1 - 3 weeks 6 - 12 months
3 - 6 weeks 1 - 2 years
6 - 8 weeks 2 - 3 years
8 - 12 weeks 3 + years

Does that pain radiate to...an arm? Right / Left
or a leg? Right / Left

Do you have weakness in...an arm? Right / Left
or a leg? Right / Left

Do you have numbness in...an arm? Right / Left
or a leg? Right / Left

Did you have an injury? yes / no If so, was it:
At work? yes / no
In a motor vehicle collision? yes / no
Other type of injury: _____
Date of injury: _____
Litigation pending? yes / no

Any difficulty controlling your bladder or bowels? yes / no

Does your pain wake you up at night? yes / no

Do you have fever, chills, or sweats? yes / no

What makes your pain better?
lying down sitting walking bending
Other: _____

What makes your pain worse?
lying down sitting walking bending
Other: _____

TREATMENT HISTORY

Did you have any of the following treatments for your pain?

Medications? Yes / No Improvement? Yes / No

If yes, which ones? _____

Physical Therapy? Yes / No Improvement? Yes / No

If yes, which ones? _____

Date of last therapy session: _____

Injections? Yes / No Improvement? Yes / No

If yes, which ones? _____

Massage? Yes / No Improvement? Yes / No

If yes, which ones? _____

Chiropractic? Yes / No Improvement? Yes / No

If yes, which ones? _____

Other? Yes / No Improvement? Yes / No

If yes, which ones? _____

Names of doctors that have treated you before for this problem:

PREVIOUS INJURIES

Have you ever had similar pain before this episode?

Yes / No If YES, when? _____

List any previous injuries, including the date of the injury.

PREVIOUS DIAGNOSTIC TESTS Please circle and date

X-Rays _____

MRI _____

CT Scan _____

Other: _____

Bone Scan _____ Dexa Scan _____

EMG/NCS _____ Discogram _____

(nerve study) _____ Myelogram _____

PAST MEDICAL HISTORY

Do you have any of the following medical problems?

AIDS/HIV yes / no Anemia yes / no

Arthritis yes / no Bleeding Probs yes / no

Cancer yes / no Diabetes yes / no

Depression yes / no Emphysema yes / no

Epilepsy yes / no Fibromyalgia yes / no

Gout yes / no Headaches yes / no

Heart Probs yes / no Hepatitis yes / no

Hypertension yes / no Kidney Probs yes / no

Migraines yes / no Muscle Diseases yes / no

NAME: _____

VISIT DATE: _____

PAST MEDICAL HISTORY Continued

Nerve Probs	y / n	Polio	y / n
Pneumonia	y / n	Stomach Probs	y / n
Psych Disorders	y / n	Thyroid Probs	y / n
Stroke	y / n	Fractures	y / n
Osteoporosis	y / n	If yes, fracture location:	

Other Medical Issues: _____

PAST SURGICAL HISTORY

Please list any previous surgeries including dates

CURRENT MEDICATIONS

Please list all medications you are currently taking, including both prescription and over-the-counter.

ALLERGIES Medications, food, and environment

SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed
 Children? yes / no Ages: _____
 Do you smoke? yes / no
 If yes, amount: _____ per day / per week
 Previous Smoking History? yes / no
 If yes, Quit Date: _____
 Previous amount? _____ per day / per week
 Do you drink alcohol? yes / no
 If yes, amount: _____ per day / per week
 Caffeine? yes / no
 If yes, amount: _____ per day / per week
 Carbonated Beverages? yes / no
 If yes, amount: _____ per day / per week
 Do you or have you used recreational drugs?
 If yes, what type? _____
 Do you live alone? yes / no
 Are you independent in normal daily activities? yes / no
 Has this changed recently? yes / no
 Assistive Devices? yes / no
 If yes, list type(s) _____

OCCUPATIONAL HISTORY

Occupation: _____
 Employer: _____
 How long have you worked there? _____ months/ yrs
 Which of the following best describes you currently?
 Working regular duty Working restricted duty
 Homemaker Unemployed
 Disabled Retired
 Not working due to: _____

If not working, date last worked: _____

Time lost from work: _____ days / wks / mnths / yrs

FAMILY HISTORY

Does any member of your family have a history of:

Anemia	y / n	Kidney Probs	y / n
Arthritis	y / n	Migraines	y / n
Bleeding Probs	y / n	Muscle Diseases	y / n
Cancer	y / n	Nerve Probs	y / n
Depression	y / n	Osteoporosis	y / n
Diabetes	y / n	Pneumonia	y / n
Emphysema	y / n	Psych Disorders	y / n
Epilepsy	y / n	Stomach Probs	y / n
Fibromyalgia	y / n	Thyroid Probs	y / n
Gout	y / n	Stroke	y / n
Headaches	y / n	Other: _____	
Heart Probs	y / n		
Hepatitis	y / n		
Hypertension	y / n		

REVIEW OF SYSTEMS

Do you **currently** have any of the following medical symptoms?

Abnormal Bleeding	y / n	Nausea	y / n
Abn. Menstrual Cycle	y / n	Numbness of Hands	y / n
Balance Problems	y / n	Numbness of Feet	y / n
Chest Pain	y / n	Runny Nose	y / n
Cold Hands / Feet	y / n	Seizures	y / n
Constipation	y / n	Shortness of breath	y / n
Cough	y / n	Skin Rash	y / n
Depression	y / n	Skin Ulcer	y / n
Ear Pain	y / n	Sleep Disturbance	y / n
Fainting	y / n	Sore Throat	y / n
Fever	y / n	Sputum Production	y / n
Growth Disturbance	y / n	Stomach Pain	y / n
Impotence	y / n	Swelling in Legs	y / n
Incontinence of Bowel	y / n	Visual Disturbance	y / n
Incontinence of Urine	y / n	Vomiting	y / n
Loss of Appetite	y / n	Weight Gain	y / n
Mania	y / n	Weight Loss	y / n
Muscle Weakness	y / n	Wheezing	y / n
Other: _____			

Form Reviewed by: _____ Date _____

Thank you for taking the time to complete this Health History and Medical Assessment.