



MEDICAL HISTORY

Full Name of Patient: _____ Date of Birth: ___M___D___Y

Please indicate if you have received any of these services for your injury/condition:

X-Ray	<input type="checkbox"/> Yes <input type="checkbox"/> No	Myelogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	General Practitioner	<input type="checkbox"/> Yes <input type="checkbox"/> No
MRI	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedist	<input type="checkbox"/> Yes <input type="checkbox"/> No
CT-Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurologist	<input type="checkbox"/> Yes <input type="checkbox"/> No
EMG	<input type="checkbox"/> Yes <input type="checkbox"/> No	Massage Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	ER Care	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever experienced the following? (If yes is checked for any item, please describe on the reverse side of this form.)

General/Constitutional		Cardiovascular			
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Recent Weight Changes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Describe:</i>			
Night Sweats/Fevers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Coronary Artery Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear-Nose-Throat	
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Loss or Ringing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Musculoskeletal		Congestive Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Problems/Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoarthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Voice Change	<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological		Gastrointestinal	
Respiratory		Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures/Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abdominal Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive Coughing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness/Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rectal Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Stones	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke/TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bowel dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hematological/Lymphatic		Ophthalmological	
Endocrine		Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glasses/Contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive Thirst/Urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Slow to Heal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred/Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Enlarged Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Disease/Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hormone Problem(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other			
Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metal Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Confusion/Memory Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Clot	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food or Medical Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Age: _____ Height: _____ Weight: _____ Dominant Hand: Left Right Dominant Leg: Left Right

We've Got Your Back!

Leisure activities and hobbies, including exercise routines: _____

Occupation or Job Title: _____

Are you currently working full time hours? Yes No

Are you on a work restriction from your doctor? Yes No

Are you latex sensitive? Yes No

Do you smoke? Yes No If so, for how long? _____ How much/day? _____

How often do you consume alcohol? Often Occasionally Never

Living situation: (*select all that apply*) House Apartment Stairs Alone Family/Roommate

During the past month, have you been feeling down, depressed or hopeless? Yes No

During the past month, have you been bothered by having little interest or pleasure in doing things? Yes No

Is this something which you would like help? Yes Yes, but not today No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? Yes No

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Have you ever taken steroid medications for any medical conditions? Yes No

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? Yes No

Please list any previous surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

What is your main complaint? _____

What date (approximately) did your present symptoms start? _____

What do you think caused your symptoms or how did this problem start? _____

Describe your pain in your own words: (Examples include dull, sharp, burning, throbbing, hot, tingling, etc.)

My pain/symptoms are currently: Getting Better Getting Worse Staying about the same

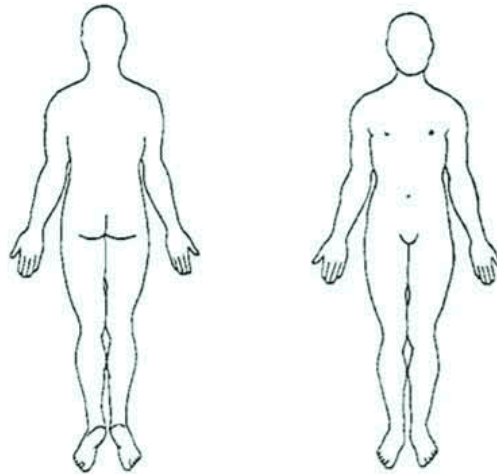
Have you had surgery for this problem? Yes No *If yes, what date and surgeon?* _____

Treatment received thus far for this problem (chiropractic, injections, therapy, MD visits, medication) _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

- ↓ Shooting/sharp pain
- Dull/aching pain
- ||| Numbness
- = Tingling



My pain/symptoms currently: Come and go Are constant Are constant, but change with activity

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
 2. _____
 3. _____
-

How are you currently able to sleep at night due to your symptoms?

- No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication
- Difficulty finding comfortable position

When are your symptoms worst? Morning Afternoon Evening Night After exercise

When are your symptoms best? Morning Afternoon Evening Night After exercise

Using the 0 to 10 scale, with 0 being “no pain” and 10 being the “worst pain imaginable” please describe:

- Your current level of pain while completing this survey: _____
- The best your pain has been during the past 24 hours: _____
- The worst your pain has been during the past 24 hours: _____