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PATIENT MEDICAL HISTORY

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

PATIENT INFORMATION			
Name *(Last, First, M.I.)*: ☐ M ☐ F		DOB:	AGE:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Patient Address: City State Zip			
Home Phone:	Cell Phone:		
SS#:	Occupation		
Employer:	Employer Phone #:		
Employer Address: City State Zip			
What type of work do you do (or did do if retired)?			
How have you been at your present job?			
Spouse / Next of Kin:	Phone #:		
Emergency Contact:	Phone #:		
Family Physician / Internist:	Phone #:		
Referring Physician:	Phone #:		
Pharmacy Name:	Phone #:		
INSURANCE INFORMATION			
PRIMARY INSURANCE:	Member/Subscriber ID:		
Address:			
Primary Subscriber:	Group Number:		
Relationship to Policy Holder: ☐ Self ☐ Spouse ☐Child			
SECONDARY INSURANCE:	Member/Subscriber ID:		
Address:			
Primary Subscriber:	Group Number:		
Relationship to Policy Holder: ☐ Self ☐ Spouse ☐Child			
CHIEF COMPLAINT/REASON FOR TODAY'S VISIT:			
Were you injured in an accident: ☐ YES ☐NO	☐Motor Vehicle Accident ☐ Worker's Comp Accident ☐ Slip& Fall ☐ Other		
Reason for Today's Visit (What are your symptoms and when did they start?)			
On a scale of 1 to 10 - One (1) being slight pain and ten (10) being severe pain, what would you rate your pain today?			
Do you have and of the following and where: (Circle which): Numbness Tingling Burning Location:			
Do you have any weakness and location: Yes No Location:			
Do you have any of the following: (Circle which): Vision problems, Hearing problems, Fainting, Dizziness, Nausea, Vomiting, Loss of Balance, LOC, Stroke, TIA or Seizures.			
What makes your symptoms worse?			

NAME: ______________________________ DOB:_______________ DATE: _____________

What makes your symptoms better?
How far are you able to walk?

CURRENT SYMPTOMS / TREATMENT:						
Have you had any of the following treatments for your CURRENT symptoms:				HAVE YOU HAD ANY OF THE FOLLOWING TESTS FOR YOU'RE YOUR PROBLEMS		
TREATMENT	YES	NO	RELIEF - NONE, SOME, GOOD		YES	NO
BED REST				CT SCAN		
ACUPUNCTURE				MYELOGRAM		
AQUATHERAPY				MRI		
PHYSICAL THERAPY				X-RAYS		
EXERCISE THERAPY				DISCOGRAM		
THERAPEUTIC MASSAGE				EMG / NCV		
TRACTION				BONE SCAN		
ELECTRO-STIMULATION				OTHER		
TENS UNIT						
SOFT COLLAR						
LUMBAR CORSET OR BRACE						
APPLICATION OF HEAT/ICE				Are you claustrophobic?		
MEDICATIONS						
CHIROPRACTIC MANIPULATION						
EPIDURAL STEROID INJECTION						
TRIGGER POINT INJECTIONS						
OTHER						

PAST MEDICAL HISTORY:					
Please list illnesses (Example: High blood pressure, diabetes, cancer, heart, lung, liver or kidney problems.					
Do you have any METAL in your body? (Pacemaker, aneurysm clips, rods, screws, shrapnel, etc) ☐ YES ☐ NO					
Have you ever been treated for any of the following:	YES	NO		YES	NO
Alcohol or Drug Abuse			Heart Attack		
Anemia			Heart Disease / Angina		
Asthma			High Blood Pressure		
Bleeding Disorder			HIV / AIDS		
Cancer			Kidney Problems		
Diabetes			Liver Problems		
Emphysema			Stroke		
Epilepsy			Ulcer		

PAST SURGICAL HISTORY: Please list all operations you have had:			
Type of Surgery	Month/Year	Surgeon	City/State

NAME: ______________________________ DOB:_______________ DATE: _____________

ALLERGIES: Please list all allergies to medications:	
Medication Name:	**Reaction**

MEDICATIONS: Please list all allergies to medications:	
Please check if you are taking any of the following: ☐Echinacea ☐ Garlic ☐ Ginger ☐ Ginko Biloba ☐ Ginseng ☐ St. John's Wort ☐ Metabolife ☐ Kava Kava ☐ Feverfew ☐ Ephedra	
Prescription Medication Name:	**Dose and Frequency**

FAMILY HISTORY: Please list any serious illnesses that have occurred in your family.			
Relative	**Living**	**Deceased**	**Health problems or Cause of Death**
Mother			
Father			
Sibling - Brother / Sister			
Sibling - Brother / Sister			
Sibling - Brother / Sister			
Child - Male / Female			
Child - Male / Female			
Child - Male / Female			

SOCIAL HISTORY:			
Marital Status: Circle one: Single Married Divorced Widowed			
Spouses Name:		Phone #:	
Tobacco use:	How much?	How often?	How long?
Alcohol use:	How much?	How often?	How long?
Caffeine use:	How much?	How often?	
Drug use:	Yes?	No?	

OTHER:	
Is there a family member or friend living with or near you who will be available to assist you once you have been discharged from the hospital should the need arise?	
Name:	Phone #:
Name:	Phone #:

NAME: ______________________________ DOB:_______________ DATE: _____________