PATIENT HISTORY

NAME: ______________________________ TODAY'S DATE: ________________

HEIGHT:__________________ WEIGHT:________________________ AGE:____________ OCCUPATION:______________________________

LEISURE ACTIVITIES:____

DESCRIBE THE REASON FOR YOUR VISIT:____

____

DATE OF INJURY/ONSET of PAIN:____ ONSET (Check One): Gradual _______ Sudden ________

HOW DID THE PROBLEM OCCUR?____

Please circle one: THE INJURY WAS A RESULT OF: CONTACT NON-CONTACT N/A

DID YOU HEAR A NOISE ASSOCIATED WITH THE ONSET OF THE INJURY?____

WHERE WAS THE PAIN INITIALLY FELT?____

WHERE IS THE PAIN NOW?____

TYPE OF PAIN:	DULL ________	SORE ________	CONSTANT ________	INTERMITTANT ________
	SHARP ________	THROBBING ________	BRUISED ________	BURNING ________

HAVE YOU HAD SIMILAR PROBLEMS IN THE PAST?____

DID YOU HAVE SWELLING IMMEDIATELY?____

WHAT IS THE LENGTH OF TIME YOUR SYMPTOMS HAVE BEEN PRESENT?____

ARE YOU CURRENTLY SEEING ANY OF THE FOLLOWING:

MEDICAL DOCTOR	YES	NO	OSTEOPATH	YES	NO
DENTIST	YES	NO	PSYCHIATRIST/PSYCHOLOGIST	YES	NO
PHYSICAL THERAPIST	YES	NO	CHIROPRACTOR	YES	NO

IF YOU HAVE BEEN SEEN BY ANY OF THE ABOVE DURING THE PAST THREE (3) MONTHS, PLEASE DESCRIBED FOR WHAT REASONS (Illness, medical condition, physical examination, etc.) :

____

PLEASE LIST ANY SURGERIES OR OTHER CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED, INCLUDING THE APPROXIMATE DATE AND REASON FOR THE SURGERY OR HOSPITALIZATION

DATE	SURGERY/HOSPITALIZATION REASON
____________________	____
____________________	____
____________________	____

PLEASE DESCRIBE ANY INJURIES FOR WHICH YOU HAVE BEEN TREATED (Including fractures, dislocations, sprains, strains and the approximate date of injury):

DATE	INJURY
____________________	____
____________________	____
____________________	____

PATIENT HISTORY PAGE 2

NAME: ______________________________________ TODAY'S DATE: ___________________

WHICH OF THE FOLLOWING OVER-THE-COUNTER MEDICATIONS HAVE YOU TAKEN IN THE LAST WEEK?:

ASPIRIN	YES	NO	TYLENOL	YES	NO
ADVIL/MOTRIN/IBUPROFEN	YES	NO	LAXATIVES	YES	NO
DECONGESTANTS	YES	NO	ANTACIDS	YES	NO
VITAMINS/MINERAL SUPPS.	YES	NO	ANTIHISTAMINES	YES	NO

OTHER:____

PLEASE LIST ANY PRESCRIPTION MEDICATIONS THAT YOU ARE TAKING (including pills, injections and/or skin patches:

____ ____

____ ____

____ ____

HOW MUCH CAFFEINATED COFFEE OR OTHER CAFFEINE CONTAINING BEVERAGES DO YOU CONSUME PER DAY?______________________

HOW MANY PACKS OF CIGARETTES DO YOU SMOKE PER DAY?____ N/A ____________

HOW MANY DAYS PER WEEK DO YOU DRINK ALCOHOL?____ N/A ____________

HAVE YOU EVER BEEN DIAGNOSED WITH THE FOLLOWING, OR HAVE YOU EVER NOTICED ANY OF THE FOLLOWING SYMPTOMS?

HEART PROBLEMS	DIAGNOSED	SYMPTOMS	NO
HIGH BLOOD PRESSURE	DIAGNOSED	SYMPTOMS	NO
ASTHMA	DIAGNOSED	SYMPTOMS	NO
EMPHYSEMA	DIAGNOSED	SYMPTOMS	NO
CHEMICAL DEPENDENCY	DIAGNOSED	SYMPTOMS	NO
THYROID PROBLEMS	DIAGNOSED	SYMPTOMS	NO
DIABETES	DIAGNOSED	SYMPTOMS	NO
MULTIPLE SCLEROSIS	DIAGNOSED	SYMPTOMS	NO
RHEUMATOID ARTHRITIS	DIAGNOSED	SYMPTOMS	NO
OTHER ARTHRITIC CONDITIONS	DIAGNOSED	SYMPTOMS	NO
DEPRESSION	DIAGNOSED	SYMPTOMS	NO
HEPATITIS	DIAGNOSED	SYMPTOMS	NO
TUBERCULOSIS	DIAGNOSED	SYMPTOMS	NO
STROKE	DIAGNOSED	SYMPTOMS	NO
KIDNEY DISEASE	DIAGNOSED	SYMPTOMS	NO
ANEMIA	DIAGNOSED	SYMPTOMS	NO
EPILEPSY	DIAGNOSED	SYMPTOMS	NO
UNEXPLAINED WEIGHT LOSS	DIAGNOSED	SYMPTOMS	NO
CANCER	DIAGNOSED	SYMPTOMS	NO

IF DIAGNOSED, PLEASE DESCRIBE THE TYPE:____

OTHER ____

DATE OF LAST PHYSICAL EXAMINATION: MONTH_______________ YEAR_______________ PHYSICIAN_______________________

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PATIENT HISTORY PAGE 3

NAME: ______________________________________ TODAY'S DATE: ___________________

HAVE YOU HAD, OR DO YOU EXPERIENCE:

CARDIOVASCULAR SYSTEM		
ELEVATED CHOLESTEROL	YES	NO
SWEATING ASSOCIATED WITH PAIN	YES	NO
PALPITATIONS	YES	NO
SWELLING OF EXTREMITIES	YES	NO
HISTORY OF SMOKING	YES	NO
ORTHOPNEA (Difficulty breathing)	YES	NO

G.U. SYSTEM			
DYSURIA (Painful urination)	YES	NO	
HEMATURIA (Blood in urine)	YES	NO	
INCONTINENCE	YES	NO	
FREQUENCY OF URINATION	YES	NO	
URINARY URGENCY	YES	NO	
VAGINAL DISCHARGE	YES	NO	N/A
AMOUNT/COLOR:_____________________			
DYSMENORRHEA (painful menstruation)	YES	NO	N/A
POST MENOPAUSAL VAGINAL BLEEDING	YES	NO	N/A
PAINFUL INTERCOURSE	YES	NO	N/A
INFERTILITY	YES	NO	
SEXUALLY TRANSMITTED DISEASE	YES	NO	

DATE OF LAST MENSTRUATION:

______/______/_______ N/A

NEUROLOGICAL SYSTEM		
ATAXIA (poor muscular coordination)	YES	NO
MEMORY LAPSES	YES	NO
CONFUSION	YES	NO
HEAD TRAUMA	YES	NO
NEUROLOGICAL DISORDER	YES	NO
TREMORS	YES	NO
SLURRED SPEECH PATTERNS	YES	NO
HEARING/VISUAL DISTURBANCES	YES	NO

GI SYSTEM		
DIFFICULTY SWALLOWING	YES	NO
HEARTBURN	YES	NO
JAUNDICE (Yellow Appearance)	YES	NO
SPECIFIC FOOD INTOLERANCE	YES	NO
CONSTIPATION	YES	NO
DIARRHEA	YES	NO
CHANGE IN COLOR OF STOOL	YES	NO
RECTAL BLEEDING	YES	NO
GALL BLADDER PROBLEMS	YES	NO
LIVER PROBLEMS	YES	NO

PULMONARY SYSTEM		
DYSPNEA (labored breathing)	YES	NO
WHEEZING	YES	NO
PROLONGED COUGH	YES	NO
SPUTUM PRODUCTION	YES	NO

ENDOCRINE SYSTEM		
EXCESSIVE THIRST	YES	NO
EXCESSIVE HUNGER	YES	NO
POLYURIA (large volume of urine)	YES	NO
EXCESSIVE SWEATING	YES	NO
FATIGUE	YES	NO
WEAKNESS	YES	NO
THYROID PROBLEMS	YES	NO

OTHER SYSTEMS		
ENT (Ears, nose , throat)	YES	NO
INTEGUMENTARY (Skin)	YES	NO
LYMPHATIC	YES	NO
PSYCHIATRIC	YES	NO