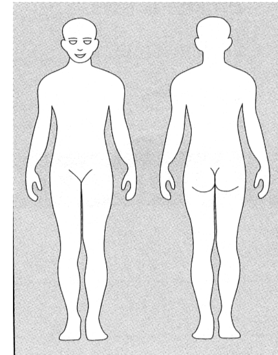
Patient History Date: ________________

Name:____ Birthdate:______________________

Address: ____

City: ______________________________ State________ Zip______________

Occupation:____



Reason for Visit____

When did your symptoms appear?___________________________________

Is this condition getting progressively worse? □ Yes □ No □ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching

□ Shooting □ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other

How often do you have this pain__________________________________

Is it constant or does it come and go?_____________________________

Activities or movements that are painful to perform □Sitting □Standing □Walking □Bending □Lying Down

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Medical History (Please Mark all that apply)

- □ Loss of Hearing
- □ Ringing in Ears
- □ Ear Infections
- □ Poor Vision
- □ Double Vision
- □ Eye Pain
- □ Eye Infections
- □ Nose Bleeds
- □ Sinus Trouble
- □ Sore Throat
- □ Allergies
- □ Hoarseness
- □ Pneumonia
- □ Bronchitis
- □ Asthma
- □ Shortness of Breath
- □ Thyroid Disease
- □ Back Pain
- □ Rashes
- □ Insomnia
- □ Memory Loss
- □ ________________
- □ Dizzy Spells
- □ Hypertension
- □ Heart Murmur
- □ Palpations
- □ Irregular Pulse
- □ Swollen Ankles
- □ Fainting Spells
- □ Chest Pain
- □ Numb Arm or Leg
- □ Loss of Appetite
- □ Indigestion
- □ Stomach Ulcers
- □ Diarrhea
- □ Constipation
- □ Bloody Stools
- □ Tarry Stools
- □ Nervousness
- □ Moodiness
- □ Depression
- □ Phobias
- □ Mental Illness
- □ ________________
- □ Hemorrhoids
- □ Blood in Urine
- □ Frequent Urination
- □ Hernia
- □ Gallbladder Disease
- □ Kidney Disease
- □ Sudden Weight Loss
- □ Fatigue
- □ Anemia
- □ Cancer
- □ Diabetes
- □ Stroke
- □ Convulsions
- □ Broken Bones
- □ Headaches
- □ Joint Pain
- □ Chicken Pox
- □ Measles
- □ Polio
- □ Mumps
- □ Tuberculosis
- □ ________________

Medications

(List any medications you are currently taking.)

____
____
____
____

Allergies

(List any allergies)

____
____
____
____

What treatment have you already received for your condition?

□ Medications □ Surgery □ Chiropractic Services
□ Physical/Occupational Therapy □ CranioSacral Therapy
□ None
□ Other____

Injuries/Surgeries	**Description**	**Date**
Falls	______________________________	__________
Head Injuries	______________________________	__________
Broken Bones	______________________________	__________
Surgeries	______________________________	__________
Birth Trauma/Injury	______________________________	__________

Exercise: □ None □ Moderate □ Daily □ Heavy

Work Activity: □ Sitting □ Standing □ Light Labor □ Heavy Labor □ Mixed

Habits: □ Smoking
Packs/day:_____
□ Alcohol
Drinks/Week:_____
□ Coffee/Caffeine
Cups/Day:_____
□ High Stress Level
Reason______________________________

If you have any questions regarding this form, or if there is other information which you have and which you feel might be important, please discuss it with your physical/ occupational therapist. Also, if any of the information which you have provided should change, you should inform your physical/occupational therapist.

Signature:____ **Date:** ____________________

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