

PATIENT HISTORY FORM

This is a confidential record and information contained here will not be released to anyone without your consent.

Today's Date ___/___/___

Date of Injury ___/___/___

Last Name _____ First Name _____ Middle _____

Social Security No. _____ Date of Birth ___/___/___

Primary Care Physician _____ Who referred you to us? _____

Do you want a report sent to this physician? _____ yes _____ no

CHIEF COMPLAINT: What is the main reason for your visit today? Describe problem in detail.

Work related? _____ Sports related? _____ Motor Vehicle Accident? _____

History of Present Illness

Where is your problem? (What Hurts?) _____

When did you first notice the problem? _____

What makes the problem worse? _____

Does activity help or make the problem worse? _____

What makes the problem better? _____

How long does the problem usually last?

Minutes _____ Hours _____ Constant _____ Occasional _____

Does the problem interfere with your normal functions? (Explain)

Have you seen another physician for this problem? (Explain)

Have you had any diagnostic studies or treatments for this problem? (X-rays, MRI, EMG, Bone Scan, Bone Density?) If so, when and where?

Pain level _____ 0-3(mild) _____ 4-6(moderate) _____ 7-10(severe)

Signature _____

Please see other side

PAST MEDICAL HISTORY

List all previous illnesses that have required medical treatment: _____

List all previous surgeries : _____

List all medications you are taking including vitamins or herbal supplements: _____

List all known drug allergies: _____

Do you smoke and how much? _____

Do you consume alcohol and how much/daily/weekly? _____

FAMILY HISTORY

List all serious illnesses in your immediate family. (Example: diabetes, cancer, etc.)

REVIEW OF SYSTEMS

Please answer yes or no to any problems related to the following systems.

Constitutional

Fever _____
Chills _____
Headache _____

Neurological

Tremors _____
Seizures _____
Dizziness _____
Numbness _____

Endocrine

Excessive thirst _____
Too cold/hot _____
Tired _____

Eyes

Blurred vision _____
Double vision _____
Pain _____

Allergic/Immunologic

Hay Fever _____
Drug allergies _____

Integumentary

Skin rash _____
Boils _____
Itching _____

Musculoskeletal

Joint pain _____
Neck pain _____
Back Pain _____

Ear/Nose/Throat

Ear infection _____
Sore throat _____

Gastrointestinal

Abdominal pain _____
Heartburn _____
Nausea/vomiting _____
Indigestion _____

Genitourinary

Urine retention _____
Painful urination _____
Incontinence _____
Frequency _____

Hematologica

Swollen glands _____
Blood clotting _____
Anemia _____
Other _____

Psychologic

Depression _____
Suicidal _____

Respiratory

Wheezing _____
Cough _____
Shortness of breath _____

Cardiovascular

Chest pain _____
Varicose veins _____
Hypertension _____
Palpitations _____
Heart murmur _____

Signature _____