



ADULT PATIENT MEDICAL HISTORY

The completion of this form is important to ensure the quality and accuracy of your care. This information is personal and confidential.

DATE: _____ PATIENT NAME: _____
 DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____
 CURRENT COMPLAINT: _____
 DURATION: _____ DATE INITIAL DIAGNOSIS GIVEN: _____

CHIEF COMPLAINT: _____

MEDICAL PROBLEMS: Include all hospitalizations or any conditions minor and /or major.

- _____
- _____
- _____

ALLERGIES: Please be sure to list any life-threatening allergies including XRAY dye, Shellfish, Iodine Adhesive tape, antibiotics or metals.

- _____
- _____
- _____

SURGERIES:

	YEAR	PROCEDURE	SURGEON	LOCATION/HOSPITAL
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- _____
- _____
- _____
- _____
- _____

ANESTHESIA COMPLICATIONS: Have you had any complications or reactions with anesthesia or anything associated with surgery? If yes, please explain.

- _____
- _____
- _____
- _____

PATIENT NAME: _____ DATE: _____

MY PAIN IS: Please check all that apply

Aching	Sharp	Penetrating	Throbbing	Tender	Electric
Nagging	Shooting	Burning	Numb	Stabbing	Constant
Exhausting	Miserable	Gnawing	Tiring	Unbearable	

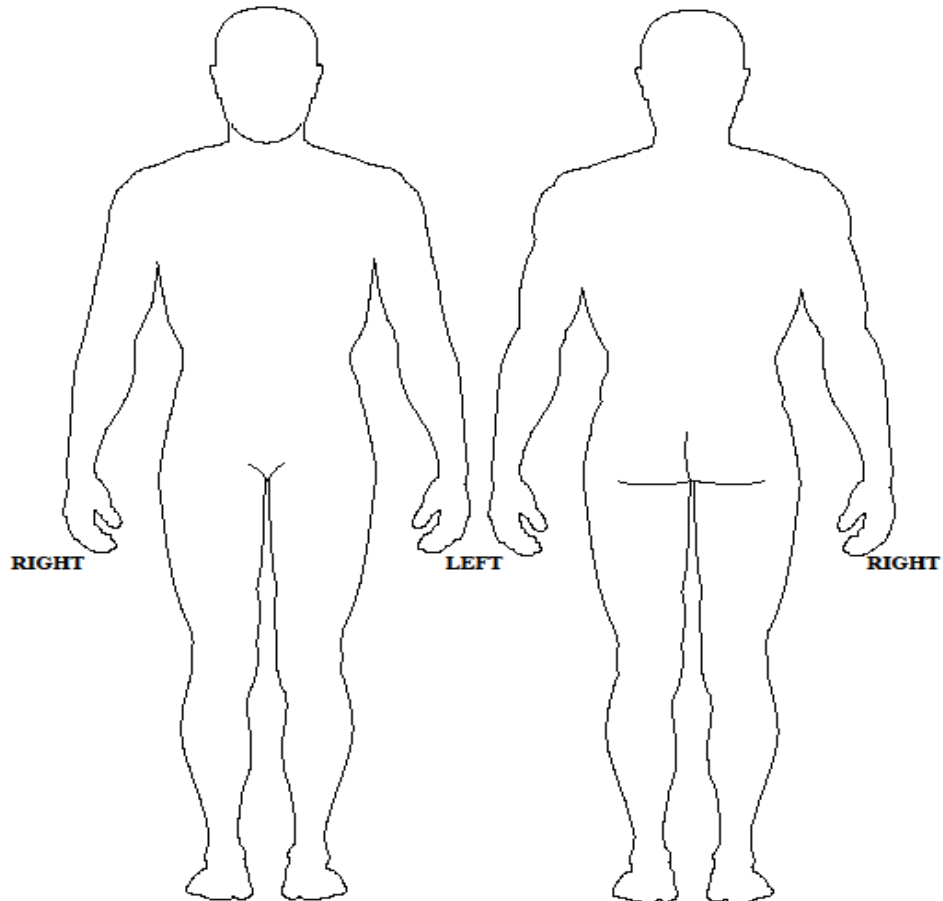
MY PAIN IS WORSE WITH:

Walking Standing Sitting Bending Working Physical Activity

My Pain is made better by: _____

Pain Drawing

Please mark below on the pain drawing where/ if you experience pain (XXX), tingling (000) or numbness (III)



PATIENT NAME: _____ DATE: _____

MEDICATION:

Please list name, dose, times per day and prescribing physician.

- _____
- _____
- _____
- _____

TREATMENT HISTORY:

YES / NO Have you tried bracing?

If yes, what type, when and for how long? _____

YES/NO Have you tried physical therapy or a core strengthening program such as pilates?

If yes, when was your last treatment session: _____

YES /NO Have you tried injections?

If yes, what types of injections/levels? Facet: _____ ESI: _____ Rhizotomies: _____

If yes, who performed the injections? _____ Phone: _____

OTHER: Please check all that apply.

Chiropractic Care Heat Ice Massage Home exercise program

Other: _____

FAMILY HISTORY:

This pertains to member of your family (blood related) ie: mother, father, grandparents.

YES/ NO Heart Attack _____

YES / NO Diabetes _____

YES / NO Heart Disease _____

YES / NO Hypertension _____

YES / NO Bleeding Problems _____

YES / NO Tuberculosis _____

YES / NO Blood Clots _____

YES / NO Scoliosis _____

YES / NO Stroke _____

REVIEW OF PERSONAL HISTORY/ SYSTEMS:

This pertains only to you, the patient.

YES / NO Chest Pain _____

YES / NO Hypertension _____

YES / NO Gastrointestinal Issues _____

YES / NO Heart Failure _____

YES / NO Lung/ Pulmonary Issues _____

YES / NO Endocrine Problems _____

YES / NO Stroke _____

YES / NO Stress Test, Heart Cath _____

YES / NO Urinary Issues _____

YES / NO Swelling in the legs _____

YES / NO Frequent Infections _____

YES / NO Hepatitis _____

YES / NO Possibility of Pregnancy _____

Last Normal Period _____ Days of cycle _____

YES / NO Pain in Legs _____

YES / NO Weakness in Legs / Arms _____

YES / NO Numbness in Leg/ Arms _____

YES / NO Have you lost or gained weight recently _____

YES / NO Excessive bleeding with surgery, nose bleeds, bruise easily _____

PATIENT NAME: _____ DATE: _____

SOCIAL HISTORY:

OCCUPATION: _____

RESIDENCE: _____

YES/ NO Are you on disability?

Are you married / single / divorced?

YES/ NO Do you have any children? If yes, how many children and their ages: _____

YES / NO Do you smoke cigarettes or cigars, dip or chew tobacco, or use any other form of nicotine product?

If yes, how many packs per day and for how many years: _____

If no, have you ever used or when did you quit: _____

YES/ NO Do you drink alcohol?

If yes, do you drink often, socially or rarely: _____ or

If yes, how many drinks do you have in a day, week or month? _____

ADDITIONAL COMMENTS: Please include any important information that was not covered in the above section that you feel will be important or pertinent to your care:

My signature below confirms that all information given is true and correct to the best of my knowledge.

Name of person completing form if other than patient: _____

Relation to the patient: _____

Signature of person completing forms: _____

Date: _____