PERSONAL HISTORY

Dear Patient, welcome to our office, this form is designed to help us to get the cause of your current health problem as quickly as possible. The more detailed and accurate you are, the better care we can provide. Your overall health is just as important to us as your current major complaints. No symptom is insignificant. The more you tell us, the more we will be able to help you achieve your health goals.

Date: _____ Email: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Business phone: _____ Birth date: _____

Age: _____ Sex: M F Height: _____ Weight: _____

Business/Employer: _____ Type of work: _____

Check one: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ DP

Spouse's name: _____ No. of children: _____ Emergency Contact: _____ Phone: _____

Referred to this office by: _____ Your Driver's Lic. #: _____

Name and address of nearest relative not living with you: _____

Are you/have you been disabled from work? _____

Current Medications: ☐ Tranquilizers ☐ Pain Killers/Muscle Relaxants ☐ Blood Pressure

☐ Insulin ☐ Aspirin/Similar ☐ Hormones ☐ Other

Specific drug or substance: _____

Natural Remedies: Vitamins/Minerals: _____

Herbs: _____

Homeopathics: _____

CURRENT HEALTH CONDITIONS

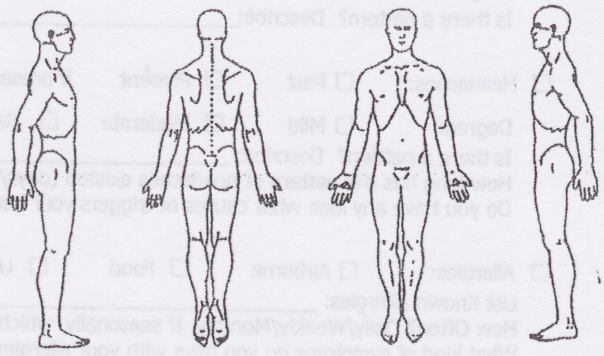
Please fill out this section for your major complaints, start with the complaint you feel is most significant and indicate on the drawing where your pain is located.

1. MAJOR COMPLAINT: _____ Date of onset: _____ ☐ Sudden ☐ Gradual

How bad is your pain or ache? Please circle a number: 0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Describe your pain or complaint:

1. ◇ Dull ◇ Sharp ◇ Ache ◇ Stabbing
   ◇ Deep ◇ Superficial ◇ Spasm/tension ◇ Numbness
   ◇ Tingling ◇ Burning ◇ Other
2. Radiation: Does the pain go to other parts of the body?
   ◇ Yes ◇ No Where? _____
3. Frequency: ◇ Occasional ◇ Intermittent ◇ Constant
4. How long does the pain last? _____
5. What makes the pain worse?
   ◇ Standing ◇ Sitting ◇ Bending ◇ Twisting
   ◇ Walking ◇ Lifting ◇ Sleeping ◇ Heat
   ◇ Cold ◇ Stooping ◇ Sex ◇ Other
6. What makes the pain better?
   ◇ Sitting ◇ Standing ◇ Rest ◇ Heat ◇ Cold
   ◇ Aspirin/medication ◇ Other _____
7. Other problems related to your main complaint: _____
8. What treatment have you received for this condition? _____



Dr.'s Notes- Please do not write in this space

_____

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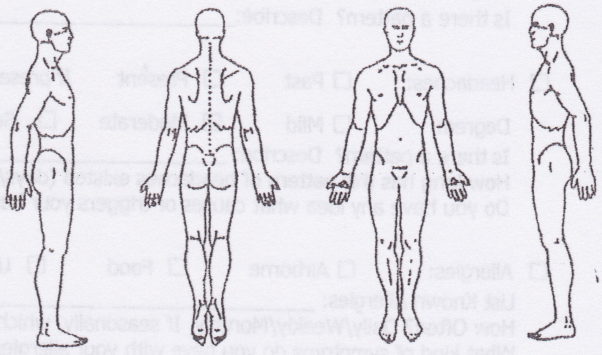

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