

**PATIENT HEALTH HISTORY**

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What condition are you being seen for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please describe your symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any other conditions that you are concerned about? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. When did your symptoms arrear or when did the accident happen?

 a. Less than 1 week ago

 b. Between 1 week and 3 months ago

 c. More than 3 months ago

 d. Date (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. How often do you experience your symptoms?

 a. Constantly (76-100% of the day)

b. Frequently (51-75% of the day)

c. Occasionally (26-50% of the day)

d. Intermittently (0-25% of the day)

4. Current symptom description. Choose all that apply.

 a. Sharp b. Dull c. Achy d. Burning e. Tingly f. Numb

 g. Shooting h. Regional i. Dizziness j. Nausea

5. What changes your symptoms?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Better | Worse | Same |  | Better | Worse | Same |
| Ice |  |  |  | Coughing/Sneezing |  |  |  |
| Heat |  |  |  | Morning |  |  |  |
| Sitting |  |  |  | Mid-Day |  |  |  |
| Standing |  |  |  | Nighttime |  |  |  |
| Walking |  |  |  | With activity |  |  |  |
| Position Changes |  |  |  | After Activity |  |  |  |
| Rising from sitting |  |  |  | During rest |  |  |  |
| Lying down |  |  |  | Sleeping |  |  |  |

6. Before today’s appointment have you received treatment for this condition?

 When? Was is helpful?

a. Chiropractor \_\_\_\_\_\_\_\_\_\_\_ yes/no

 b. Physical Therapy \_\_\_\_\_\_\_\_\_\_\_ yes/no

 c. Home Care \_\_\_\_\_\_\_\_\_\_\_ yes/no

 d. Medication/Injections \_\_\_\_\_\_\_\_\_\_\_ yes/no

 e. Surgery \_\_\_\_\_\_\_\_\_\_\_ yes/no

 f. None \_\_\_\_\_\_\_\_\_\_\_ yes/no

 g. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ yes/no

7. Have you received any special testing for this condition?

 a. X-ray

 b. CT Scan

 c. MRI

 d. EMG

 e. None

 f. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Have you had this condition before? Yes / No.

 If yes, when?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. What is your current status?

 a. Employed

 b. Unemployed

 c. Student

 d. Retired

 e. Homemaker

 f. Disabled

10. What is/was your occupation?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. If employed, are you:

 a. Working in your normal position without any restrictions?

 b. Working in your normal position with restrictions?

 c. Working in an alternate position?

d. Not currently working due to your condition?

12. What are your primary job tasks/activities/functions? Choose all that apply.

 a. Prolonged sitting

b. Prolonged standing

c. Lifting

d. Driving

e. Operating machinery

f. Repetitive tasks (i.e. using a computer, writing, phone work, assembly, etc)

13. Please circle any of the following health conditions which you are currently have or are being treated for or have had in the past or have been treated for in the past.

Anemia Diabetes Incontinence Overweight/Obese

Arthritis Emphysema Kidney Disease Seizures

Asthma Heart Problems Menopause Stroke

Cancer (type:\_\_\_\_\_\_\_\_\_\_) Hepatitis Mental Illness Thyroid Disease

Chemical Dependency High Blood Pressure Multiple Sclerosis Tobacco Use (now or past)

Depression History of Fractures Osteoporosis Tuberculosis

None

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. If applicable, please list **any** surgeries you have had.

**Surgery: Date:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. Please circle and list any medications that you are currently taking, either over the counter or prescription.

 a. Cardiac Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 b. Anti-Inflammatory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 c. Hormone Replacement Therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 d. Pain Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 e. Anti-Seizure Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 f. Muscle Relaxers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 g. Thyroid Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 h. Steroids: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 i. Heparin/Coumadin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 j. Anti-Depressants: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 k. Medication to increase bone density: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 l. Blood pressure medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 m. None

 n. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. What is that date of your last full physical examination?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. Women: Are you pregnant or is there and possibility you may be pregnant?

 **Yes No Uncertain**

18. What type of exercise do you typically perform?

 a. Light

 b. Moderate

 c. Vigorous

 d. None

19. What is your current height and weight?

 Height: \_\_\_\_\_\_\_ ft. \_\_\_\_\_\_\_ in.

 Weight: \_\_\_\_\_\_\_lbs.

**PATIENT SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\* We reserve the right to charge a $42 dollar fee for ‘no show’ or failure to cancel appointments.**

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