Patient History: New Patient/Reactivate

Name: _____ DOB:_____ Date: _____

What are your symptoms? Briefly list all that apply with the most severe listed first.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

How did your symptoms occur? _____

Date symptoms began (approximate): _____

Have you missed any work or school? If so, how much? _____

Did you have any similar pain or any other pain before this occurred? _____

Have you seen anyone for this condition previously? Who? _____

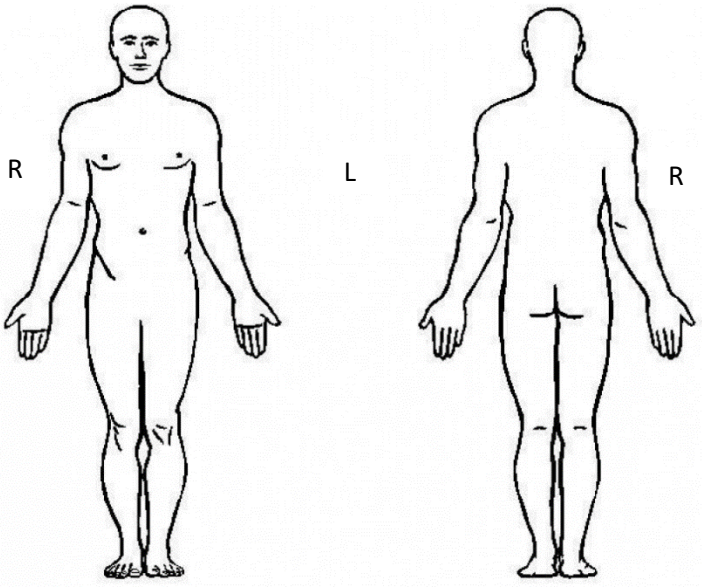
Have there been any prior treatments? Circle all that apply: Surgery, Injections, Physical Therapy, Prescription medications, Over the Counter medication, Massage, Acupuncture, other_____

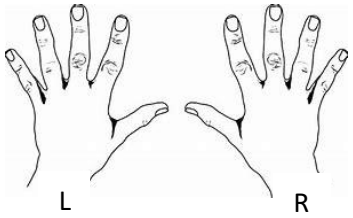
Did you notice relief with any of the above prior treatments? _____

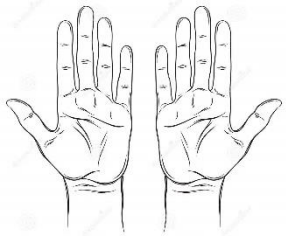
Have you ever had this condition before? No 1-3 times 4+

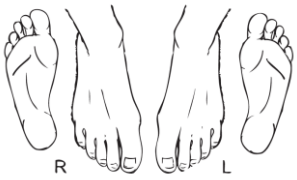
What makes your condition better? _____

Using the provided pain key, mark the figure(s) below where you are experiencing pain.









Pain Key

(((Achy Pain

::: Sharp Pain

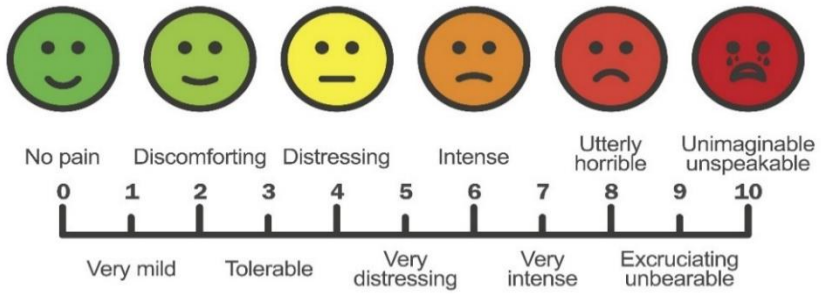
XXX Burning Pain

---- Numbness

000 Pins/Needles

Clinic Use Only: Height: _____ Weight: _____ Blood Pressure _____/_____

For this section, according to the areas you marked that have pain, provide a number out of 10 for when the pain feels its *best*, its *worst*, on *average* this last week, and right *now*. **If you do not have pain in a specific area listed, leave it blank.**



Headaches:	Best: _____/10	Worst_____/10	On average_____/10	Right now_____/10
Neck:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Mid back:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Low back:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Hip:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Shoulder:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Arm:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Hand:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Leg:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Knee:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Foot:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Other:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10

If you have neck and/or back pain, circle your answers below when considering the last week:

1. **On average, how would you rate your pain?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
2. **How much has your pain interfered with your daily activities?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
3. **How much has your pain interfered with your recreational, social and family activities?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
4. **How much has your pain contributed to depressed feelings?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
5. **How much as your pain contributed to anxious feelings?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
6. **How have you felt your work has affected your pain?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
7. **How much have you been able to control your pain on your own? (10=no control)**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10

Past Medical History

Have you had any x-rays taken of the area in the last two years? _____

Females only: Are you pregnant? ☐ No ☐ Yes-Due Date: _____

Describe any major illnesses, injuries, falls, hospitalizations, accidents, or surgeries below:

Date:	Condition:
_____	_____
_____	_____
_____	_____

Social History

Are you a student? ☐ No ☐ Yes

Occupation: _____ Years with employer? _____ Hours/Week? _____

Recreational/Hobbies: _____ Do you exercise? How often? _____

Do you consume caffeine? ☐ No ☐ Yes: How much and how often? _____

Do you consume alcohol? ☐ No ☐ Yes: How much and how often? _____

Select your smoking status: ☐ Everyday ☐ Some days ☐ Former ☐ Never

Family Health History

List any current or past health conditions of your family members. If deceased, indicate at what age.

Father: _____

Mother: _____

Sisiter(s): _____

Brother(s): _____

Children: _____

Allergies

☐ None

Allergies to medications	Allergies/Intolerances to food	Other
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medications

☐ None

Name of Prescription	Dose (mg, mL)	Form	Duration
_____	_____	_____	___x per _____
_____	_____	_____	___x per _____
_____	_____	_____	___x per _____
_____	_____	_____	___x per _____
_____	_____	_____	___x per _____
_____	_____	_____	___x per _____

System Review

Circle any following conditions you have now or in the past.

Eyes: Glasses | Contacts | Pink Eye | Glaucoma | Macular Degeneration | Cataracts

Ears, Mouth, Nose, Throat: Ear Infection | Hearing Loss | Sinus Infection | Nasal Polyps

Cardiovascular: Heart Murmur | Irregular Heartbeat | Hypertension | Heart Disease | High Cholesterol

Respiratory: Lung Disease | Difficulty Breathing | Asthma | Bronchitis | COPD | Emphysema | Pneumonia

Neurological: Weakness | Numbness

Endocrine: Thyroid Problems | Hormonal Imbalance | Liver Disease | Kidney Disease | Diabetes

Gastro-Intestinal: Acid Reflux | Colic | Constipation | IBS | Crohn's Disease | Stomach Ulcer | Intestinal Ulcer

Genito-Urinary: Bed Wetting | Kidney Stones | UTI

Musculoskeletal: Fractures | Dislocations | Spondylolisthesis | Sprain/Strain | Arthritis

Skin: Rashes | Dryness | Psoriasis | Hair Loss | Eczema

Psychiatric: Anxiety | Depression | Bipolar | ADD/ADHD | PTSD

List any other health conditions you may have: _____

Try to rate **3 Activities of Daily Living** that apply to you. Firstly, mark whether the activity is *limited*, *painful* or *difficult* to do. Then, provide a number out of 10 for when the pain feels its *best*, its *worst*, on *average* this last week, and right *now*. **If an activity does not bother your symptoms, leave blank.**

L- Limited *P- Painful* *D- Difficult*

Example: **L** Sitting to Standing: Best **1**/10 Worst **8**/10 On average **5**/10 Right now **3**/10

____**Sitting to Standing:**	Best _____/10	Worst____/10	On average_____/10	Right now____/10
____**Lifting:**	Best _____/10	Worst___/10	On average_____/10	Right now_____/10
____**Twist/turn:**	Best _____/10	Worst___/10	On average_____/10	Right now_____/10
____**Turning in bed:**	Best _____/10	Worst___/10	On average_____/10	Right now_____/10
____**Dressing Self:**	Best _____/10	Worst___/10	On average_____/10	Right now_____/10
____**Reaching:**	Best _____/10	Worst___/10	On average_____/10	Right now_____/10
____**Standing**:	Best _____/10	Worst___/10	On average_____/10	Right now_____/10
____**Walking:**	Best _____/10	Worst___/10	On average_____/10	Right now_____/10
____**Bending**:	Best _____/10	Worst___/10	On average_____/10	Right now_____/10
____**Sitting**:	Best _____/10	Worst___/10	On average_____/10	Right now_____/10
____**Using Computer:**	Best _____/10	Worst___/10	On average_____/10	Right now_____/10
____**Using Stairs**:	Best _____/10	Worst___/10	On average_____/10	Right now_____/10
____ **Other**:	Best ___/10	Worst_____/10	On average_____/10	Right now_____/10