
PATIENT HISTORY HEALTH QUESTIONNAIRE

Name: _____ Today's Date ____ / ____ / ____

Date of Birth: ____ / ____ / ____ Age: _____ Sex: Male ____ Female ____

What is your current complaint? _____

How did you get injured? _____

Date of injury or onset of symptoms: ____ / ____ / ____

Is your condition job related? ____ YES ____ NO

Is there any possibility that you are pregnant? ____ YES ____ NO

KNOWN DRUG ALLERGIES? ____ YES ____ NO

If yes, list the allergy and your reaction.

Referred by: _____

Name of your medical doctor: _____

Telephone number for medical doctor: (____) - _____

Address for medical doctor: _____

List **CURRENT MEDICATIONS**: Include over-the-counter and herbal medication.

Please continue on the next page

MEDICAL HISTORY:

Height: _____ Weight: _____

Medical Tests Already Done: X-RAYS MRI CAT SCAN BONE SCAN

MYELOGRAM EMG/NCS OTHER: _____

Have you had back problems previously? _____ YES _____ NO

Have you had neck problems previously? _____ YES _____ NO

If so, have you seen any other doctor for this problem? (List below)

What type(s) of treatment(s) have you received for your back or neck?

What aggravates or makes your pain worse? (check all that apply)

During Exercise _____ Stress _____ Bending Forward _____

After Exercise _____ Sex _____ Bending Backward _____

Sitting _____ Morning _____ Coughing _____

Standing _____ Night _____ Sneezing _____

Walking _____ Fatigue _____ Touching Skin _____

Damp Weather _____ Cold Weather _____ Work Activities _____

Twisting _____

Other: _____

Please continue on the next page

What relieves your pain or makes it less? (check all that apply)

Lying Down _____ Heat/massage _____ Injections _____
 Sitting _____ Medications _____ Exercise _____
 Standing _____ Walking _____ Physical Therapy _____
 Alcohol _____ Ice _____ Nothing _____

Other: _____

What activities of daily living can you do now? (check all that apply)

Drive _____ Housework _____ Work at a Job _____
 Walk _____ Sit _____ Stand _____
 Climb Stairs _____ Yard Work _____ Get Dressed _____

Do you now have or have you ever had any problems related to the following?

Please circle YES or NO.

<u>Constitutional</u>			<u>Respiratory</u>		
Fever (unexplained)	Y	N	Pneumonia	Y	N
Chills	Y	N	Asthma	Y	N
Night Sweats	Y	N	Emphysema	Y	N
Weight loss (unexplained)	Y	N	Bronchitis	Y	N
			Tuberculosis	Y	N
<u>Eyes</u>					
Visual Changes	Y	N	<u>Gastrointestinal</u>		
Glaucoma	Y	N	Abdominal Pain	Y	N
			Blood in Stool	Y	N
<u>ENT</u>			Nausea/vomiting (not due to flu)	Y	N
Loss of Hearing	Y	N	Indigestion/Heartburn	Y	N
Sinus Problems	Y	N	Stomach Ulcers	Y	N
			Irritable Bowel Syndrome	Y	N
<u>Psychiatric</u>					
Depression	Y	N	<u>Miscellaneous</u>		
Sleeping Disorder	Y	N	History of Alcohol Abuse	Y	N
			History of Drug Abuse	Y	N
			Hepatitis	Y	N
			Liver Disorders	Y	N

Please continue on the next page

REVIEW OF SYSTEMS CONTINUED.

Cardiovascular			Genitourinary		
Heart Attack	Y	N	Bladder Problems	Y	N
Mitral Valve Prolapse	Y	N	Frequent Urinary Infection(s)	Y	N
Abnormal Heart Rhythm	Y	N	Blood in Urine	Y	N
High Blood Pressure	Y	N	Kidney Stones	Y	N
Stroke / Mini - Stroke	Y	N	Kidney Failure	Y	N
Aneurysm	Y	N			
Poor circulation in legs	Y	N	Neurological		
Raynaud's Disease	Y	N	Dizzy Spells	Y	N
			Seizures or Convulsions	Y	N
Musculoskeletal			Headaches	Y	N
Back Pain	Y	N	Multiple Sclerosis	Y	N
Osteoporosis	Y	N			
Arthritis	Y	N	Endocrine		
			Diabetes	Y	N
Integumentary/Breast			(please circle choice below)		
Skin Rash	Y	N	Adult Onset		
Sore that will not heal	Y	N	Juvenile Onset		
Breast lump/discharge	Y	N	Insulin Dependent		
			Non-Insulin Dependent		
Hematologic/Lymphatic			Thyroid Dysfunction	Y	N
Anemia	Y	N	Gout	Y	N
Bruise Easily	Y	N			
Sickle Cell Disorder	Y	N	History of Cancer (Personal)	Y	N
Blood Clots	Y	N			
Aids or HIV	Y	N	Type: _____		
Enlarged Lymph Nodes	Y	N	_____		
Lupus	Y	N			

Any other medical illness not listed above: _____

PAST SURGICAL HISTORY:

Have you ever had an operation? If yes, list the operation and year they were performed.

Please continue to the next page.

SOCIAL HISTORY:

What is your occupation? _____

Specific Duties: _____

Are you working? _____ YES _____ NO

If no, what is the last date you worked? _____ / _____ / _____

If yes, are you working with restrictions? _____ YES _____ NO

Does your employer have light duty available? _____ YES _____ NO _____ unknown

Have you ever been injured on the job before? _____ YES _____ NO

If yes, far what reason? _____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Use of alcohol: Never _____ Rarely _____ Moderate _____ Daily _____

Use of tobacco: Never _____ Previously, but quit _____ Current packs per day _____

Use of illegal/street drugs: Never _____ Type/Frequency: _____

Are you on any special diet? _____

Hobbies: _____

Sports: _____

Do you CURRENTLY exercise? _____ YES _____ NO If yes, what type of exercise do you do and how many times per week? _____

FAMILY HISTORY:

Who, if anyone, in your family has or has had any of the following:

Diabetes _____ High Blood Pressure _____

Heart Disease _____

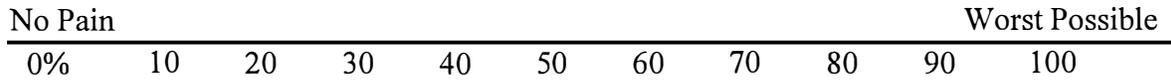
Cancer _____

Stroke _____

Please continue on the next page.

PAIN INTENSITY RATING

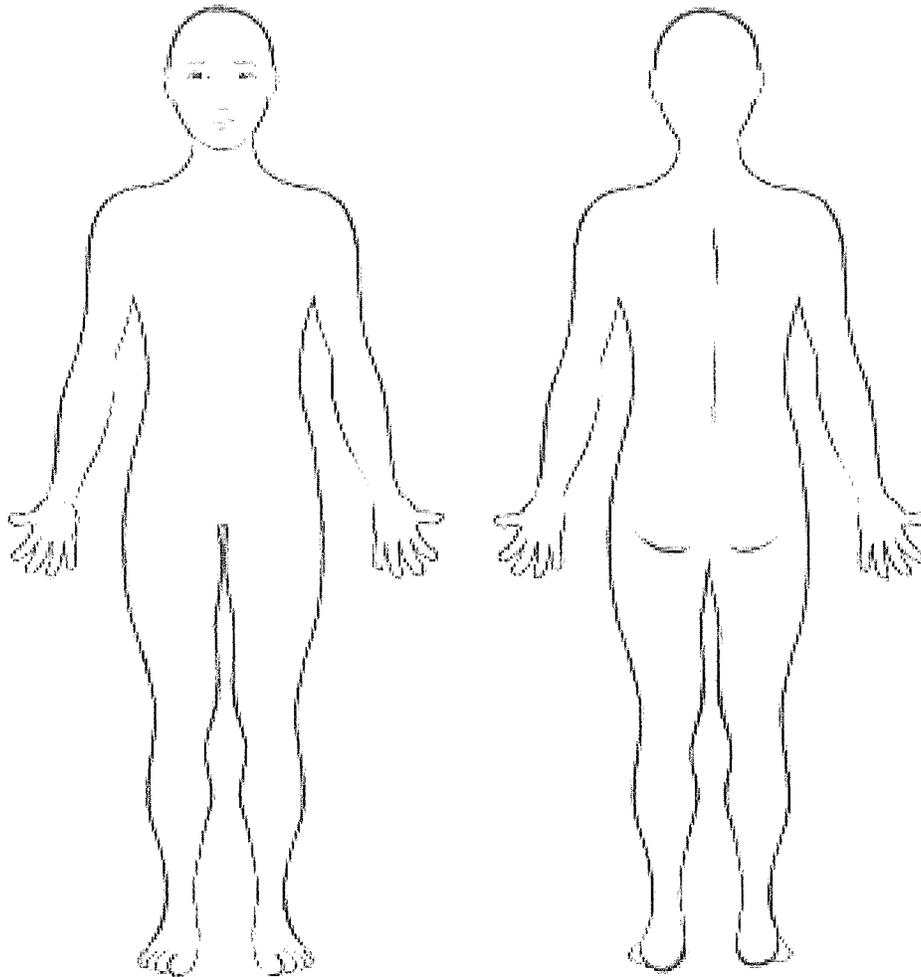
On the line below, CIRCLE your AVERAGE PAIN over this last week.



WHERE IS YOUR PAIN NOW?

Use appropriate symbols shown below to mark the areas on your body where you feel these described sensations. Include ALL areas affected by your pain, and mark the type and area of pain if it radiates or spreads to other areas.

Burning X	Numbness O	Pins/Needles =	Stabbing /	Ache Δ
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Physician Initials _____ Date _____