

CONFIDENTIAL PATIENT HISTORY

Date: _____

PATIENT INFORMATION

TITLE: (Check one) Mr. Mrs. Ms. Dr. Other _____

First Name _____ **Middle Initial** _____ **Last Name** _____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **Zip Code** _____

Home Phone (____) _____ - _____ **Cell Phone** (____) _____ - _____

Email _____

Date Of Birth ____ / ____ / ____

Primary Care Physician _____

How did you hear about our office?

Google Referred by Dr. _____ Referred by Attorney _____

Referred by Friend/Family Member _____ Other _____

Employment Status: Employed as _____ Unemployed

Emergency Contact

Contact Name _____ **Relationship To Patient** _____

Contact Phone Number (____) _____ - _____ **Cell Phone** (____) _____ - _____

HEALTH INFORMATION

Medications: _____

Allergies: _____

Medical Conditions:

Cancer Arthritis Diabetes Thyroid Disorder Osteoporosis Hypertension

Stroke Heart Disease Other _____

Prior Injuries or Trauma

Please list injury, date, and treatment (if any) _____

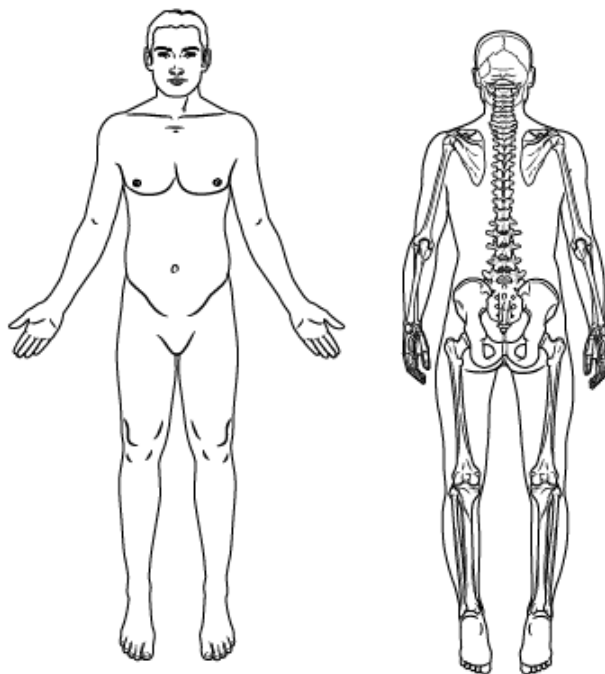
Prior Surgeries

- Cervical Spine Lumbar Spine Shoulder (L/R) Elbow (L/R) Wrist (L/R) Hip (L/R)
- Knee (L/R) Ankle (L/R) Other _____

Family History

- Cancer Arthritis Diabetes Thyroid Disorder Osteoporosis Hypertension
- Stroke Heart Disease Other _____

Please indicate on the body diagram where you are experiencing pain, numbness, or tingling:



Primary Complaint: _____

When and how did this begin? _____

Does your pain radiate? If so indicate where: _____

Severity from 1-10: _____ **How often do you feel it?** _____

The pain worsens with: _____

The pain is alleviated by: _____