

Health History								
Patient Name:				Birth date:		Date:		
Chief Complaint:								
History of Present Injury:								
<i>Severity</i> (How severe is the pain/problem on a scale of 0-10?)								
<i>Duration</i> (How long have you had this pain/problem?)								
<i>Context</i> (Where were you at the onset of this pain/problem?)								
<i>Timing</i> (Does the pain/problem occur at a certain time?)								
<i>Location</i> (Where is the pain/problem?)								
<i>Description</i> (How would you describe the pain/problem?)								
<i>Associated signs/symptoms</i> (Other associated problems?)								
<i>Modifying factors</i> (What makes the pain/problem better/worse?)								
<i>Anything else you want us to know about your condition?</i>								
Past Medical History:								
Have you ever had the following? Circle N or Y or leave blank if uncertain.								
Chickenpox	N	Y	Heart Disease	N	Y	Vision issues	N	Y
Whooping Cough	N	Y	High Blood Pressure	N	Y	Multiple Sclerosis	N	Y
Tuberculosis	N	Y	Low Blood Pressure	N	Y	Dizziness/Vertigo	N	Y
Aids or HIV	N	Y	Mitral Valve Prolapse	N	Y	Chronic cough	N	Y
Thyroid Disease	N	Y	Migraine Headaches	N	Y	Asthma	N	Y
Epilepsy	N	Y	Infectious Mono	N	Y	Hernia	N	Y
Kidney Disease	N	Y	Stroke	N	Y	TMJ issues	N	Y
Hepatitis	N	Y	Diabetes Type 1	N	Y	Chronic back problem	N	Y
Ulcer	N	Y	Diabetes Type 2	N	Y	Arthritis	N	Y
Bleeding Tendency	N	Y	Cancer	N	Y	Depression	N	Y
Anemia	N	Y	If yes, type: _____			Anxiety	N	Y
How many hours do you sleep per night? ____ <7 ____ 7-9 ____ >9						Pregnancy	N	Y
How many car accidents have you been involved in? ____						# of vaginal births ____	Year(s):	
How much alcohol do you drink? ____ drinks/day ____ drinks/week						# of c-sections ____	Year(s):	
How many days/week do you exercise? ____						Do you smoke?	N	Y
Exercise/activities/sports you enjoy:								
Previous hospitalizations/surgeries/serious illnesses:								
Medications (including over-the counter medications):								
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my medical status.								
Signature of patient, parent or guardian:							Date:	