



Patient Name \_\_\_\_\_ Referring Dr. \_\_\_\_\_ Date \_\_\_\_\_ Acct.# \_\_\_\_\_

**Current Medical History:**

Present Problem: What specifically brings you to see the doctor today? Please describe your symptoms (i.e. right leg and back pain, etc.)

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

When did the symptoms begin? (month/year) \_\_\_\_\_

Is your problem a result of an accident?  Yes  No

Or a workers' compensation case?  Yes  No

When did your injury occur? (date) \_\_\_\_\_

Is a lawsuit in progress or being planned?  Yes  No

Please list all other doctors and chiropractors who you have seen for this problem and the tests that have been preformed.  
(i.e. x-rays, MRI's, EMG's, Cat Scans, etc.)

DATE	DOCTOR	TESTS	LOCATION TEST WAS DONE
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you been in physical therapy?  Yes  No

If so, where? \_\_\_\_\_ For how long? \_\_\_\_\_ Starting when? \_\_\_\_\_ Ending when? \_\_\_\_\_

Have you used any sort of brace or support?  Yes  No Wrist splint for Carpal Tunnel?  Yes  No

Please list all medications you are currently taking and the frequency. Please include any regular and occasional medications as well as over-the-counter medications.

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

Do you have any drug allergies?  Yes  No

If yes, please list all of your allergies.

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

Do you smoke cigarettes?  Yes  No How many packs per day? \_\_\_\_\_

Do you use alcohol?  Yes  No How many drinks per day? \_\_\_\_\_

Do you use any "street" drugs?  Yes  No

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_

Patient Name \_\_\_\_\_ Acct # \_\_\_\_\_

Please list all surgeries, your surgeons and the dates of the surgeries.

Surgery	Surgeon	Date

How many pregnancies? \_\_\_\_\_ How many births? \_\_\_\_\_

Please list all hospitalizations, your doctors and the dates you were hospitalized.

Reason for Hospitalization	Doctor	Date

**Social History:**

Are you currently employed?  Yes  No Where \_\_\_\_\_ Occupation \_\_\_\_\_

When was your last day of work? \_\_\_\_\_

If off work on disability, Name of Physician keeping you off work \_\_\_\_\_

**Family History:**

	Current Age	Age at Death	Health Problems or Cause of Death
Father			
Mother			
Sisters			
Brothers			
Daughters			
Sons			

**Past Medical History:**

Please check any of the following medical problems you have and explain *the* problem in the space provided below.

**GENERAL  
GENITAL/URINARY**

- Cancer
- Arthritis
- Lupus
- Thyroid Problems
- Diabetes
- Other \_\_\_\_\_

**LUNG**

- Asthma
- Bronchitis
- Pneumonia
- Emphysema
- Tuberculosis
- Other \_\_\_\_\_

**BLOOD**

- Anemia
- Bleeding Disorders
- Previous Transfusion
- Other \_\_\_\_\_

- Kidney Problems
- Kidney Stones
- Urinary Tract Infection
- Prostate or Bladder Problems
- Other \_\_\_\_\_

**CARDIOVASCULAR**

- High Blood Pressure
- Heart Attack
- Heart Pain
- Chest Pain
- High Cholesterol
- Other \_\_\_\_\_

**GASTROINTESTINAL**

- Ulcers
- Colitis
- Liver Disease
- Hepatitis
- Shortness of breath with activity

**NEUROLOGICAL**

- Stroke
- Multiple Sclerosis
- Parkinson's Disease
- Seizures or Epilepsy
- Head Injury
- Neck or Back Injury
- Headaches
- Other \_\_\_\_\_

Do you have a pacemaker?  Yes  No