PATIENT HISTORY

Date of initial evaluation:_____

Patient's Name:_____ ID#:_____

DOB:_____ Age:_____ Sex:____ Male ____ Female

Date of accident/injury:_____ Type: MVA____ WORK____ OTHER____

Seen in emergency room:____Yes ____No Name of Hospital:_____

X-Ray/MRI/CT-Scan Taken:____Yes ____No What Facility:_____

Chief Complaint(s):

_____

_____

History of present illness: (When did your problem start) _____

_____

Past Medical History:

Prior Surgery:____Yes ____No
If yes please provide type of surgery and when surgery was done:_____

_____

_____

Medical illness:____Yes ____No
If yes please provide type of illness:_____

_____

_____

Medication:_____

_____

_____

Prior injuries:____Yes ____No
If yes please describe type of injury and when it occurred:_____

_____

_____

Prior treatment/physical therapy:____Yes ____No
If yes please provide when and for what:_____

_____

_____

Allergies:_____Yes ____No
If yes please provide type:_____

Family History:
Mother_____ State of Health_____
Father_____ State of Health_____

Social History: _____Smokes _____Alcohol _____Drugs
Civil Status: _____Single _____Married _____Widowed _____Divorced

Children:_____
Occupation:_____

PATIENT HISTORY CONTINUED

Patient's Name:_____ ID#:_____

Review of symptoms: Check those that apply.

HEAD, EARS, EYES, NOSE & THROAT
____Headaches
____Glaucoma
____Hearing Deficits
____Dizziness
____Difficulty Swallowing
____Blurry Vision
____Speech Defect
____Persistent Hoarseness
____Cough (Chronic)
____TMJ

CARDIOVASCULAR
____High Blood Pressure
____High Cholesterol
____Poor Circulation
____Rheumatic Fever
____Chest Pain
____Palpations
____Heart Murmur
____Heart Attack
____Arteriosclerosis

RESPIRATORY
____Shortness of Breath
____Bronchitis
____Pleurisy
____Asthma
____Emphysema
____Tuberculosis/Lung Disease
____Chronic Respiratory
____COPD

GENERAL:
____Bipolar Syndrome
____Thyroid
____Diabetes
____Anemia
____Blood Clots/DVT's
____Pressure Ulcers/Wounds
____Hepatitis/Liver Disease
____HIV/Blood Disorder
____Venereal Disease:_____
____Problems with prostate/reproductive organs
Pregnant:_____(Months/Gestational)
Cancer_____
Cyst_____
Tumor_____
Lymph Glands_____
Skin Problems_____
Other_____

NEUROLOGICAL
____Stroke/CVA
____Fainting
____Convulsions
____Numbness
____Tingling
____Head Injury
____Seizures
____Shingles

GASTROINTESTINAL
____GERD/Acid Reflux
____Intestinal Bleeding
____Ulcer
____Hernia
____Appendicitis
____Colitis
____Diverticulitis
____Hemorrhoids
____Recurrent Indigestion
____Change in Bladder/Bowel Habits

MUSCULOSKELETAL
____Fibromyalgia
____Lupus
____Arthritis
____Rheumatoid Arthritis
____Osteoarthritis
____Neuritis
____Sciatica
____GOUT
____Osteoporosis/T-Score_____
____Lyme Disease
____Bone or Joint Injuries

Have you traveled outside the United States in the last 2 months? Yes_____ No_____

Patient's Signature & Date_____

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