CONFIDENTIAL PATIENT HEALTH HISTORY FORM
Name:
Date:
During the past week:
a. Indicate the average intensity of your symptoms
None **0 1-2-3-4-5-6-7-8-9-10** *Unbearable*
b. How much has the pain interfered with your work activities (Such as your job, yardwork, laundry, dishes or house cleaning)?
Not at al, A little bit, Moderately, Quite a bit, Extremely
C. How much has the pain interfered with your social activities (Such as visiting with friends, golfing and dancing)?
Not at all, A little bit, Moderately , Quite a bit , Extremely
What makes your symptoms worse?
Standing, Sitting, Walking, Bending, Lifting, Activity, Rest
What makes your symptoms better?
Ice, Heat, Sitting, Standing, Activity, Rest, Medication
Who have you seen for your current symptoms?
This office, Medical Doctor, Other Chiropractor, Physical Therapist, Surgeon
a. What kind of treatment did you receive?
Adjustments, Injections, Medications, Other, Therapy/Rehab, Surgery
b. What tests have you had for your symptoms and when were they performed?
X-rays date:
CT scan date:
MRI date:
Have you had similar symptoms in the past? Yes No
a. If you have received treatment in the past for the same or similar symptoms, whom did you
This office, Medical Doctor,Other: Other Chiropractor, Physical Therapist, Surgeon
What is your occupation?
Professional/Executive, White Collar/Secretarial,
Student, Homemaker, Retired, Other: Laborer, Tradesperson
In general, how would you say your overall health is right now?
Excellent, Very Good, Good, Fair, Poor
Have you ever had any of the following traumas or injuries?
Auto Accident, Work Injury, Knocked Unconscious, Whiplash Injury, Head Trauma Required Stitches
Other: Sport Injury, Broken Bone, Slip or Fall

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Date:
Name:
Please circle your symptoms
Headache, Neck, upper back, Mid-back, Low-back, Shoulder, Hip, other
What do you think caused this problem?
Auto Accident, Slip or Fall, Lifting, An Awkward Motion,
Prolonged Activity, Repetitive Movement,
Prolonged Position, Overexertion, other, Don't Know
When did your symptoms start?
How often do you experience your symptoms?
Constantly (between 75 to 100% of the day)
Frequently (between 50 to 75 % of the day)
Occasionally (between 25 to 50% of the day)
Intermittently (between 0 to 25% of the day)
What best describes the nature of your symptoms?
Sharp, Dull, Burning, Tingling
Dull ache
Dull ache with episodes of sharpness
How have your symptoms been changing?
Getting Better, Staying the Same, Getting Worse

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Date:
Name:
Do you have any Family History of the following? (mother, father, brother's or sister's)
Auto-immune Disease, Bleeding Disorders, Clotting Disorder, Cancer
Diabetes, Heart Disease, High Blood Pressure, Kidney Disease, Osteoporosis
Stroke, Thyroid Disease, Other:
Social History:
a. Smoking: Current Smoke, r Past Smoker, Never a Smoker
b. If you are a past or current smoker. How many packs per day?
C. If a past how long did you smoke or current smoker, how long have you been smoking ?
d. Alcohol: Beer, Wine, Liquor
e. How much alcohol consumption?
Daily, weekly, monthly
Medical:
Date of last exam:
Family Medical Doctor:
Address:
Patient Signature
Do Not Write Below This Line-Staff Use Only

NOTES