# PATIENT HEALTH HISTORY

PATIENT NAME:_____ DATE:_____

**1**. Describe your primary complaint and where is it located:(Head, Neck, Upper Back, Mid Back, Lower Back, Hips, etc)

_____

How did this happen: _____

-What makes your complaint feel **better**? _____
-What makes your complaint feel **worse**? _____
-How **long** have you had this complaint?_____(days, months, years)
-Is your complaint getting better or worse? _____
-**When** is this complaint most troublesome?_____day / night / morning
-Describe your symptoms: __sharp __ache __numb __shooting pain __burning __tingling
__ radiating __other:_____

Rate your pain on a scale of 1-10. 10 being the most severe pain.
1 2 3 4 5 6 7 8 9 10

**2**. Describe any other complaint(s) and where they are located:(Head, Neck, Upper Back, Mid Back, Lower Back, Hips, etc)

_____

How did this happen: _____

-What makes your complaint feel **better**? _____
-What makes your complaint feel **worse**? _____
-How **long** have you had this complaint?_____(days, months, years)
-Is your complaint getting better or worse? _____
-**When** is this complaint most troublesome?_____day / night / morning
-Describe your symptoms: __sharp __ache __numb __shooting pain __burning __tingling
_ radiating __other:_____

Rate your pain on a scale of 1-10. 10 being the most severe pain.
1 2 3 4 5 6 7 8 9 10

**3**. How often do you experience your symptoms?
_____ Constantly _____ Intermittently _____ Occasionally

**4**. How have your complaints affected your everyday life, do you have trouble with any of the following due to your symptoms?

__ Personal Care __ Concentration __Sleeping __ Sitting __ Lifting __ Work
__ Recreation __ Walking __ Reading __ Driving __ Standing __ Travel

**5**. Are you taking any prescription or over the counter medications, please list_____

_____

**6**. Have you seen any other physicians for your complaints?
__ NO __YES Who?_____

**-----OVER PLEASE-----**

**7**. Have you had any treatment/tests done in the past or scheduled in the future for your condition/s?
__NO __Yes, please list_____

**8**. Past / Current health conditions:_____

**9.** Past Hospitalizations: _____

**10**. Surgeries past or future: _____

**11.** Broken Bones / Major Injuries:_____

**12.** Are you currently pregnant?_____

**13.** Do you have any allergies?_____

**14**. Have you been in an automobile accident? ____Past 5 years ____Over 5 years ____Never

**15**. What family medical history do you have that might relate to your condition?

_____

**16.** Do you sleep on your ____back ___stomach _____side?

**17**. Are you wearing ____heel lifts ___sole lifts ____inner soles ____arch supports?

**18**. Do you have pain in your feet? ___YES ___NO

**19**. Do you wear high heel shoes? ___YES ___NO

**20**. Do you have pain when you cough or sneeze? ___YES ___NO

**21**. Do you carry a large or heavy purse? ___YES ___NO

**22**. Do you wear a thick billfold in your back pocket? ___YES ___NO

**23**. Do you smoke or drink alcohol: ___ no smoking or drinking ___currently smokes, does not drink
____no smoking, drinks alcohol socially ____ smokes, drinks alcohol socially

**24**. Are you comfortable in your car? ___YES ___NO

**25**. Do you have pain in the jaw? ___YES ___NO

Printed Name: _____

Signature: _____