

Health History

Name of Patient: _____ Date: ____/____/____

Purpose of this appointment: _____

Explanation of how problem occurred: _____

Date of Onset: ____/____/____ Gradual or Sudden Symptoms: _____

On the job: ____Yes ____No Days off work: _____

Auto Accident: ____ Yes ____No Days off work: _____

Female: Last date of Menstrual Cycle _____

Pregnant: _____NO _____YES

Bowel or Bladder irregularities: Y N _____

Abdomen/Chest/Stomach/Throat Problems: Y N _____

Location of problem: _____

Frequency of Problem/Pain: _____

Any Problems to Extremities (arm/leg area, etc.): Y N _____

Prior Occurrences: Y N When: _____ Worse: A.M. P.M.

What makes it better: _____ Worse: _____

What were/are you doing for the Problem/Pain: _____

Does Problem/Pain Affect Sleep: Y N History of Trauma to Area: Y N _____

Sleeping positions: ____ On back, ____ On side, ____ Side w/ arm extended, ____ On stomach

Past history of family illnesses or diseases:

Diet: How many Meals a day: ____ Servings of meat: ____ Vegetables: ____ Fruit: ____

Activities/Hobbies: _____

Other/Comments: _____



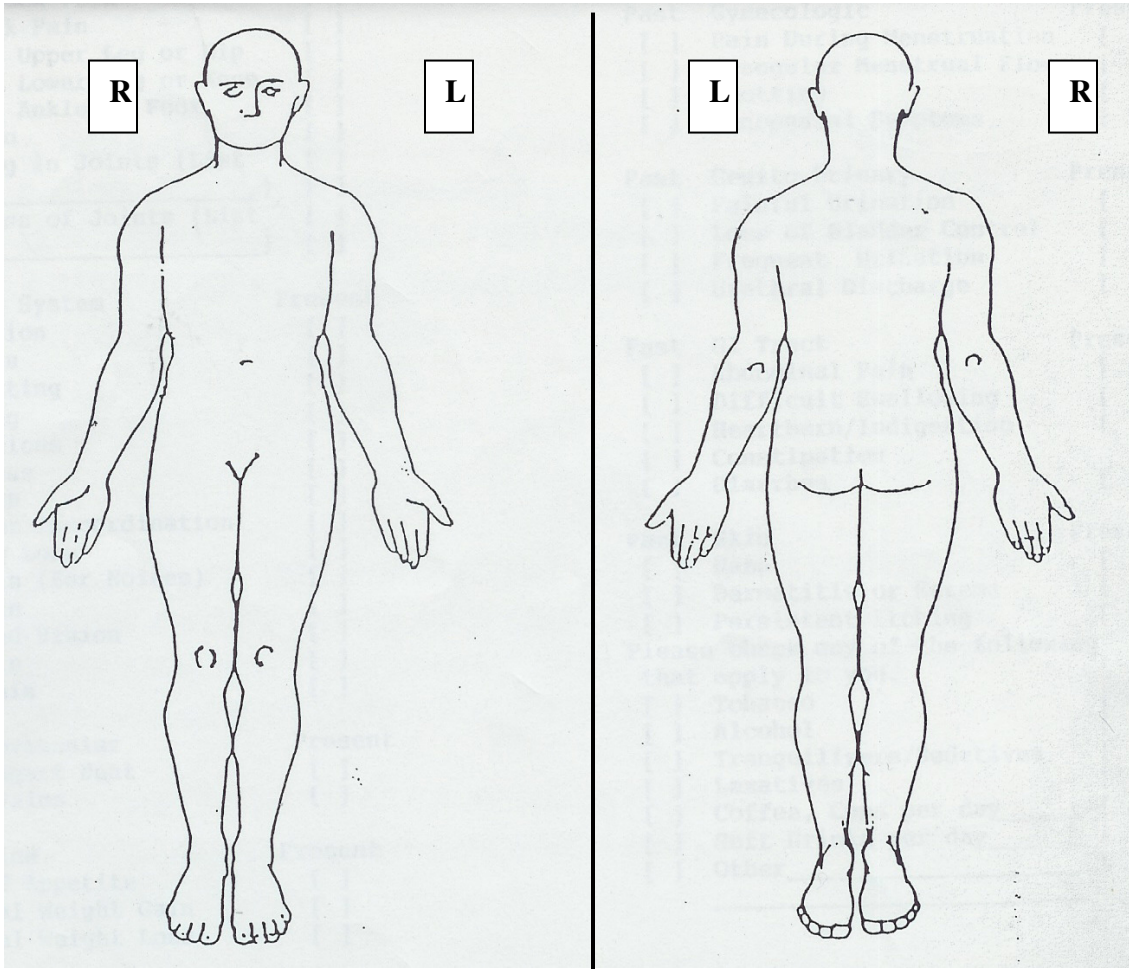
PAIN DRAWING

Name: _____ Date: ____/____/____

Please be sure to fill out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate letter(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Please mark on the picture where you have symptoms according to the indicated codes.

Stabbing Pain	ssssss	Aching	aaaaaa	Numbness	nnnnnn	Tingling	tttttt	Burning Pain	bbbbbb
	ssssss	(stiffness)	aaaaaa		nnnnnn	(pins & needles)	tttttt		bbbbbb



Please mark on the lines the **pain level** that most accurately represents your pain using the number pain scale below:

Right Now _____
 Average Pain _____
 At Best _____
 At Worst _____

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 **UNBEARABLE PAIN**