HEALTH INFORMATION FORM

TODAY'S DATE:_____

PATIENT'S NAME:_____DOB:_____

FAMILY DOCTOR:_____REFERRING DOCTOR:_____

CHIEF COMPLAINT: (Please describe your pain including location. Include a description of typical day and limitations.)

_____

_____

_____

HISTORY OF PRESENT ILLNESS:

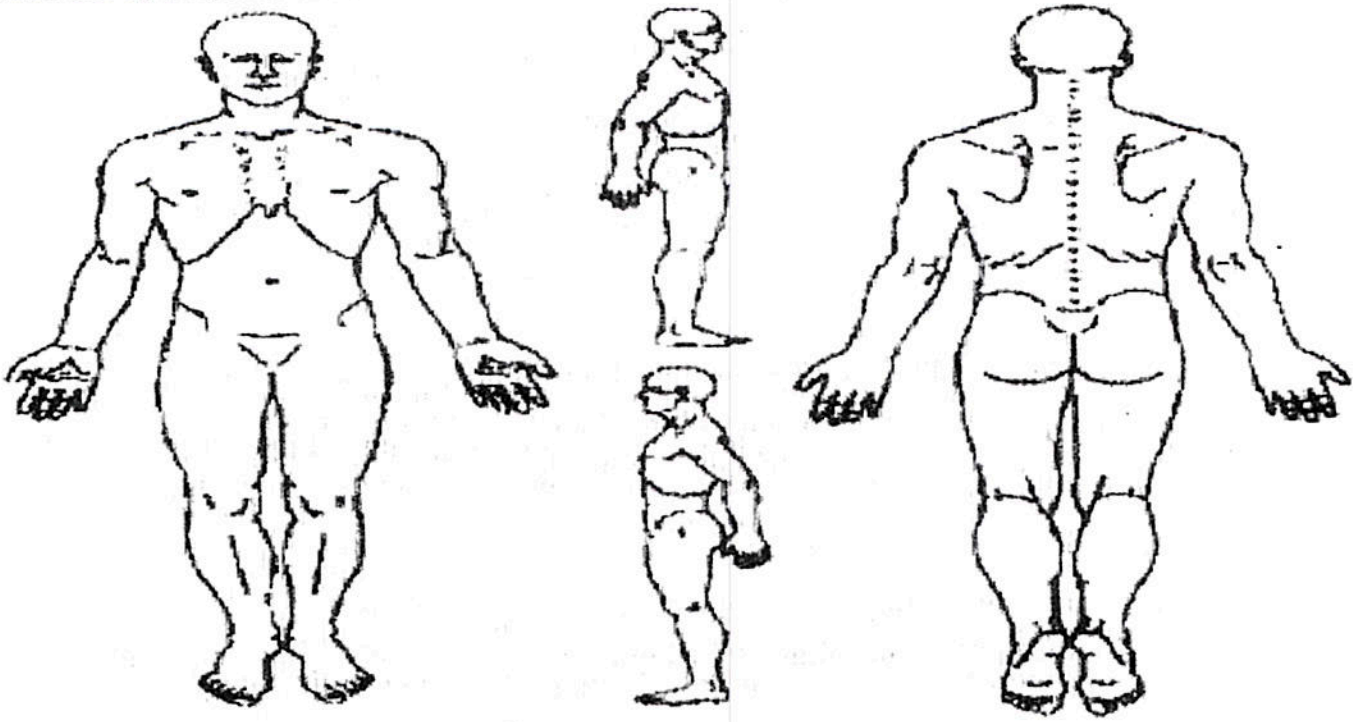
When did you first notice symptoms? _____

Was the onset of this: GRADUAL SUDDEN

How often do you experience the pain? AM PM DAILY WEEKLY (circle all that apply)

As the day progresses, do your symptoms increase, decrease or remain the same?_____

Shade the appropriate areas of Pain or Abnormal Sensation:



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On a scale of 0-10 (10 being emergency room pain) please rate your present level of pain.

1 2 3 4 5 6 7 8 9 10

What is the worse pain you experience on a scale of 0-10? _____

What is the best the pain gets on a scale of 0-10? _____

What is an acceptable level of pain for you on a scale of 0-10, with 10 being the worse?

What aggravates your symptoms? (circle all that apply)

Sitting	Standing	Repetitive Activities	Lying Down
Swallowing	Stress	Household Activities	Up/Down stairs Bending
Squatting	Talking	Reaching overhead	Reaching Behind Back
Walking	Coughing	Others_____	

What relieves your symptoms? (Circle all that apply)

Sitting	Stretching	Cold	Heat	Alcohol
Elevating Limbs	Wearing Splints	Standing	Massage	Traction
Lying Down	Exercise	Whirlpool	Walking	Rest
Medication	Other:_____			

What previous treatments have you had? (Circle all that apply)

None	Exercise	Injection into Spine	Injection into Muscles
Bracing	Oral Medication	Biofeedback	Massage Therapy
Hypnosis	TENS Unit	Traction	Joint Manipulation
Physical Therapy	Acupuncture	Casting	

PAST MEDICAL HISTORY (Circle all the apply)

Diabetes	Emphysema	Deep Vein Thrombus	Arthritis
Rheumatoid Arthritis	Multiple Sclerosis	Osteoporosis	Polio
Hypertension	Stomach Ulcers	Cancer, Type_____	Other_____

PAST SURGICAL HISTORY:

Surgery & Date:_____

SOCIAL HISTORY

Do you smoke/use tobacco products? Y N If yes, how much?_____

Do you drink? Y N If yes, how much?_____

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FAMILY HISTORY: (List all serious illnesses in your immediate family, identifying who has/had the illness)
Example: diabetes, TB, breast cancer, Heart Disease, hypertension, strokes, cancer.

Illness	Family Member	Notes
_____	_____	_____
_____	_____	_____

OCCUPATIONAL HISTORY

Are you currently working? Y N
If NO: Date last worked:_____
Are you retired: Y N
Are you on Disability? Y N
If yes, first date on disability_____
If YES: Job title/Description:_____Hrs worked/day_____Days a wk_____

Doses your job require? (circle all that apply)

Bending	Twisting	Pushing	Lifting
Kneeling	Ladder Climbing	Pulling	Overhead Work

REVIEW OF SYSTEMS: (Do you now or have you had any problems related to the following systems?) Circle Yes or No

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other_____		

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other_____		

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other_____		

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other_____		

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Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N

Other_____

Endocrine

Excessive Thirst	Y	N
Too hot/cold	Y	N
Tired/Sluggish	Y	N

Other_____

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N

Other_____

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N

Other_____

Genitourinary

Painful Urination	Y	N
Urine Retention	Y	N
Urinary Frequency	Y	N

Other_____

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N

Other_____

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting problem	Y	N

Other_____

Are you currently pregnant? Y N

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other_____

Are you allergic to any medications? Y N

If yes, please list_____

Are you allergic to Bee Stings? Y N

Are you allergic to any foods? Y N

If yes, please list:_____

HEALTH INFORMATION FORM

CURRENT PAIN MEDICATIONS (Please list all medication your are currently taking INCLUDING over the counter & supplements)

NAME OF MEDICATION	DOSAGE	WHEN DO YOU TAKE	HOW OFTEN