PATIENT HISTORY

PATIENT NAME _____ REFERRED BY _____

DATE OF FIRST OFFICE VISIT _____

1. Please list your bone, joint, muscle, or nerve problems: _____
   _____
   _____
   _____
   _____
   Date these problems began: _____

   Have you ever had the same (or similar) problems before that time? (circle) YES NO
   Cause of the current problem (circle): Work Injury Auto Accident Illness Sports Injury
   Other _____

2. If pain is present, what makes it worse? (circle): Walking – Running – Turning – Standing – Kneeling – Bending – Carrying – Lifting – Driving – Lying Down – Straining – Twisting – Jumping – Throwing – Pushing – Pulling – Coughing/Sneezing – Climbing/Descending Stairs – Weather Changes – Sitting – Squatting – Stooping – Reaching – Grasping – Writing – Typing
   Other _____

   What makes it better? (circle): Walking – Standing – Sitting – Heat – Lying Down – Massage – Rest – Physical Therapy – Exercises – Ice – Corset – Splint/Brace – Firm Mattress – Traction – Special Shoes/Inserts – Chiropractic Manipulation – Cortisone Injection(s) – Surgery – Alcohol – Medicines – Decreased Stress

   Is the pain (circle): Worse in the morning – Worse in the midday – Worse in the evening – Present all day – Associated with headaches – Awakening you at night – Associated with stiffness – Associated with popping?

   Do you have any (circle): Numbness – Tingling – Weakness – Popping – Grinding – Swelling?

3. Have you ever had a permanent disability award or rating for a work injury?_____
   When? _____

4. PAST MEDICAL HISTORY
   Special tests (circle): Myelogram – CT scan – Electrical Nerve Test – Bone Scan – MRI
   Other injuries (list and give dates): _____
   _____
   _____
   _____