HISTORY & PHYSICAL

Patient Name______________________________ **OFFICE USE ONLY: Weight**_____ **Height**____
DOB______________ **Date**____________________ **Referring Source**______________________

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
# of Children: _______son(s) _______daughter(s)
Current Work Status: Full-Time Part-Time Unemployed Disabled Retired Student Homemaker`
If working, ☐ Regular Duty ☐ Light Duty ☐ with restrictions ☐without restrictions
If not working, how long have you been off due to current symptoms?______________________________
Occupation______________________________Employer______________________________
Do you consume alcohol? ☐ Never ☐ Occasionally ☐ Moderate ☐ Heavy
Do you smoke or use tobacco? ☐ Current ☐ Former ☐ Never
If so, how many packs per day?______ How long?_______ Quit date?________

MAIN COMPLAINT

PRESCRIBED & OVER THE COUNTER MEDICATIONS

Medication:	Dosage and Frequency:	Medication:	Dosage and Frequency:

Are you allergic to any medications? ☐ Yes ☐ No If yes, list medications and type of reaction:

Medication:	Reaction:	Medication:	Reaction:

Are you allergic to any **latex** products? ☐ Yes ☐ No

PAST MEDICAL HISTORY:

Have you <u>ever</u> had any of these conditions? If so, please check the line and give the year you were treated.

☐ Headache/migraine__________
☐ Headache/tension __________
☐ Epilepsy/seizures __________
☐ Stroke __________
☐ Head Injury __________
☐ Cervical Spine Disease __________
☐ Lumbar Spine Disease __________
☐ Brain Tumor __________
☐ Depression __________
☐ Coronary Artery Disease __________
☐ Heart Attack __________
☐ Heart rhythm problems __________
☐ Congestive heart failure __________
☐ Heart Murmur __________
☐ High Blood Pressure __________
☐ Pacemaker __________
☐ Emphysema __________
☐ Pneumonia __________
☐ Asthma __________
☐ Ulcer Disease __________
☐ Colon polyps __________
☐ Anemia __________
☐ Diabetes __________
☐ Circulation problems __________
☐ Thyroid Disease __________
☐ Menstrual problems __________
☐ Sexual Dysfunction __________
☐ Liver Disease __________
☐ Kidney disease __________
☐ Bladder/prostate problems __________
☐ Hepatitis __________
☐ Venereal disease/STD __________
☐ Arthritis __________
☐ Cancer __________
☐ Tuberculosis __________
☐ HIV __________
☐ Mumps __________
☐ Measles__________
☐ Polio __________
☐ Rheumatic Fever __________
☐ Allergy/Hay Fever __________
☐ Metallic Implants__________

Patient Name_______________________________ **Date**________________________

PRIOR SURGERIES/HOSPITALIZATIONS

List all operations, hospitalizations or biopsies and what year you had them:

Reason	Year	Reason	Year

Have you had a previous neck or back issue or injury? ☐**No** ☐**Yes**

REVIEW OF SYSTEMS – GENERAL

Do you *currently* have any of the following conditions? If so, please check.

__ Fatigue
__ Weight loss
__ Fevers
__ Depression
__ Ear, nose or throat
__ Heart
__ Lung
__ Circulation
__ Stomach, intestine, or bowel
__ Kidney or Bladder
__ Muscle, bone, or joint
__ Skin
__ Blood
__ Other

REVIEW OF SYSTEMS – NEUROLOGIC

Do you *currently* have any of these conditions? If so, please check.

__ Headache
__ Dizziness
__ Fainting
__ Fevers
__ Chills
__ Weight Loss
__ Confusion
__ Concentration Problems
__ Memory Problems
__ Nausea
__ Vomiting
__ Trouble with smell
__ Blurred Vision
__ Loss of vision
__ Double vision
__ Facial Numbness or tingling
__ Difficulty Chewing
__ Choking
__ Drooling
__ Difficulty Tasting
__ Ringing of ears
__ Decreased hearing R/L
__ Difficulty swallowing
__ Hoarseness
__ Poor balance
__ Seizures
__ Hallucinations
__ Speech difficulty
__ Personality change
__ Poor coordination
__ Trouble walking
__ Loss of control of bladder
__ Loss of control of bowel
__ Numbness in genital area
__ Severe pain or weakness in legs

FAMILY HISTORY

If unknown, please indicate your reason. ☐ Adopted Other (please specify)___________

Check if any ***blood relative*** has or has had any of the following medical illnesses and enter the ***maternal/paternal*** relationship if applicable:

		Relationship:
Stroke	_____	______________
High Blood Pressure	_____	______________
Diabetes	_____	______________
Cancer	_____	______________
Leukemia	_____	______________
Bleeding Tendency	_____	______________
Kidney Disease	_____	______________
Goiter	_____	______________
Arthritis	_____	______________
Gout	_____	______________
Heart Attack	_____	______________
Rheumatic Heart	_____	______________
Congential Heart Defect	_____	______________

		Relationship:
Heart Rhythm Problems	_____	______________
Pacemaker	_____	______________
Multiple Sclerosis	_____	______________
Death w/out known cause	_____	______________
Stomach Ulcers	_____	______________
Colitis	_____	______________
Asthma	_____	______________
Hay Fever	_____	______________
Emphysema	_____	______________
Tuberculosis	_____	______________
Migraine	_____	______________
Mental Illness	_____	______________
Alzheimer's	_____	______________

Patient Name_______________________________ **Date**__________________________

HISTORY OF PRESENT ILLNESS

Location of affected area:

☐ Back ☐ Neck ☐ Head

☐ Arm	☐ Hands	☐ Hip	☐ Legs	☐ Shoulders	☐ Foot
☐Right	☐Right	☐Right	☐Right	☐Right	☐Right
☐Left	☐Left	☐Left	☐Left	☐Left	☐Left
☐Bilateral	☐Bilateral	☐Bilateral	☐Bilateral	☐Bilateral	☐Bilateral

Symptoms:

☐ Pressure ☐ Numbness ☐ Tingling ☐ Weakness ☐ Stiffness ☐ Burning

Pain:

☐ Sharp ☐ Dull ☐ Dull, but Sharp with movement

Severity of Symptoms: ☐ Mild ☐ Moderate ☐ Severe

How long have you had these symptoms? ______________________________

Onset of Symptoms:

- ☐ Gradually Getting Worse
- ☐ Improving
- ☐ With Injury on: ___________________
- ☐ Gradual
- ☐ Sudden

Frequency of Symptoms:

- ☐ Constant
- ☐ Positional(when sitting, standing, etc.)
- ☐ Rare – Weekly or Monthly
- ☐ Once per day
- ☐ Several times per day

Relieved by:

☐ Heat ☐ Ice ☐ Sitting ☐ Standing ☐ Walking ☐ Brace ☐ Pain Meds ☐ Aquatic Therapy

☐ Leaning forward ☐ Lying down ☐ Changing positions ☐ Massage ☐ Nothing

Worsened by:

☐ Heat ☐ Ice ☐Sitting ☐ Standing ☐ Walking ☐ Brace ☐ Pain Meds ☐ Aquatic Therapy

☐ Leaning forward ☐ Lying down ☐ Changing positions ☐ Massage ☐ Bending ☐ Lifting

☐ Getting out of bed ☐ Getting up from a sitting position ☐Movement ☐Riding in a car ☐ Twisting

☐ Exercise ☐ Prolonged position ☐ Nothing
- ☐ Standing
- ☐ Sitting

Patient Name________________________ **Date**________________________

HISTORY OF PRESENT ILLNESS

Have you seen other physicians for this problem? ☐ Yes ☐ No
If so, please provide the names of the physician(s) along with the dates treated:

____

____

Have you tried any of the following treatments?

☐ Rest

☐ Medications

☐ Chiropractic Care
- ☐ with relief
- ☐ with no relief
- # of visits____

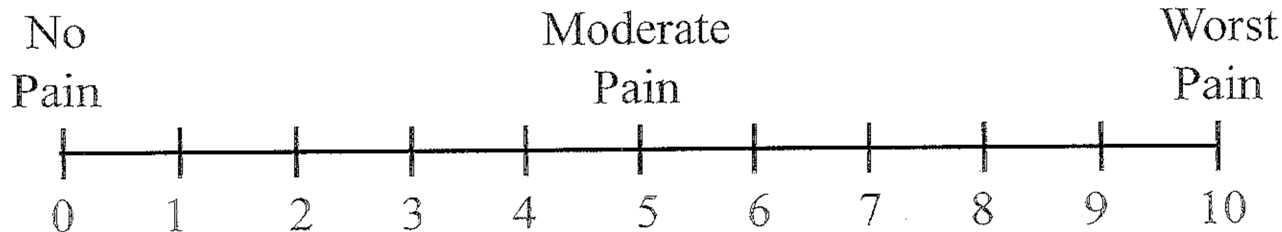
☐ Physical Therapy
- ☐ with relief
- ☐ with no relief
- Times per week ____
- # of weeks____

☐ Epidural Steroid Injections
- ☐ with relief
- ☐ with no relief
- # of injections____

Name ______________________________ Date: ______________

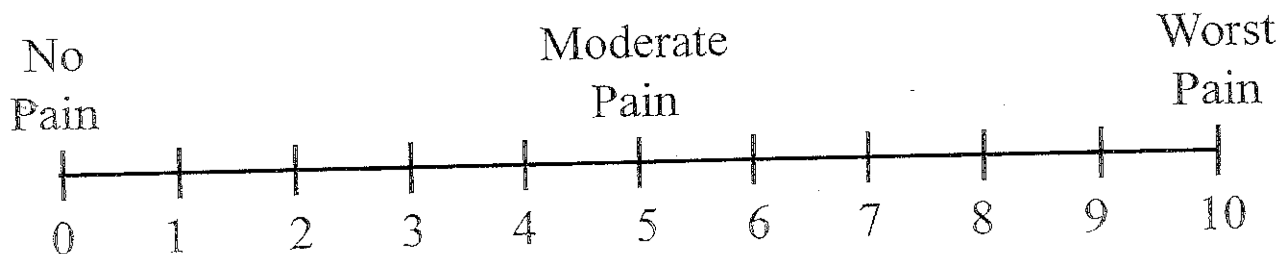
Do you have back pain?

Yes___ No___ If so, how would you rate it?



Do you have leg pain?

Yes___ No___ If so, how would you rate it?



Do you have neck pain?

Yes___ No___ If so, how would you rate it?