



# PATIENT HISTORY QUESTIONNAIRE

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Marital Status (circle): Married Partnered Engaged Separated Divorced Single

Social Security # (for Insurance Verification): \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

What complaint brings you in today?  
\_\_\_\_\_  
\_\_\_\_\_

Have you seen any other providers for today's complaint(s)? **Yes No** If yes, list their name and specialty:  
\_\_\_\_\_  
\_\_\_\_\_

What types of treatment(s) have you received, if any, for your presenting condition(s)?  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any tests (X-rays, MRI, CT, Blood work) for your current complaint(s)? **Yes No** If Yes, Describe  
\_\_\_\_\_  
\_\_\_\_\_

### Please complete the following for your complaint

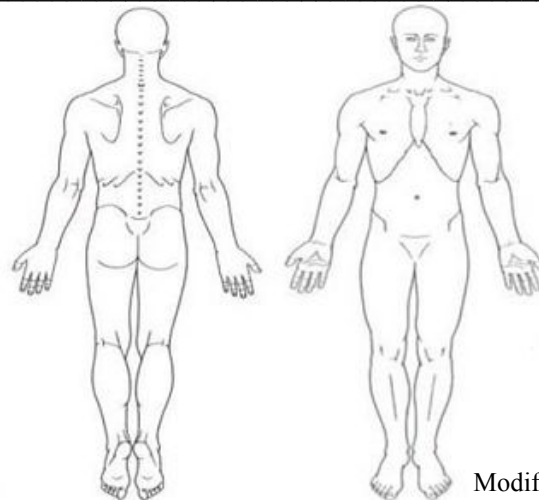
Rate pain on a scale of 0-10 (10 being the most severe pain you've ever experienced):

(circle) 0 1 2 3 4 5 6 7 8 9 10

- What type of pain are you experiencing?  
 Sharp/Stabbing  Ache  Dull  Burning  Throbbing  Numbness  Tingling  Cramping
- How long have you had this pain? \_\_\_\_\_
- What makes the pain worse? \_\_\_\_\_
- What makes the pain better? \_\_\_\_\_
- Does the pain travel? \_\_\_\_\_ If so, where? \_\_\_\_\_
- Is pain worse at any particular time of day? \_\_\_\_\_
- Date of onset \_\_\_\_/\_\_\_\_/\_\_\_\_
- Date of same or similar symptoms \_\_\_\_/\_\_\_\_/\_\_\_\_

To help us better understand the nature & origin of your complaints, please complete this drawing. Use the symbols listed below to detail where you hurt and how you hurt.

- ////////// Dull Ache/Throb
- XXXXXX Sharp/Stabbing
- BBBBBB Burning
- OOOOOO Numbness
- ..... Tingling
- CCCCCC Cramping



**Overall Health**

Please list other Medical Problems you may be seeing other providers for: (List issue & provider)

---



---

Have you ever had X-rays, MRI or CT or any other tests (e.g. EKG, blood work) for the other Medical Problems you are being treated for? Yes No If Yes list below:

Study/Test: \_\_\_\_\_ Date: \_\_\_\_\_ Treatment received: \_\_\_\_\_

Study/Test: \_\_\_\_\_ Date: \_\_\_\_\_ Treatment received: \_\_\_\_\_

Does your past history include any hospitalizations or surgeries? Yes No If Yes, please describe

---



---

What medications, supplements and vitamins are you currently taking? (please include dosages)

---



---

Please Check the following you are currently taking or have taken in the past 3 months:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> vitamins         | <input type="checkbox"/> anti-depressants   | <input type="checkbox"/> heart medications         | <input type="checkbox"/> birth control pills  |
| <input type="checkbox"/> herbs            | <input type="checkbox"/> weight loss pills  | <input type="checkbox"/> blood pressure medication | <input type="checkbox"/> stomach/GI           |
| <input type="checkbox"/> laxatives        | <input type="checkbox"/> thyroid medication | <input type="checkbox"/> blood vessel drugs        | <input type="checkbox"/> reflux medicine      |
| <input type="checkbox"/> muscle relaxants | <input type="checkbox"/> insulin            | <input type="checkbox"/> blood thinners            | <input type="checkbox"/> cold/cough medicine  |
| <input type="checkbox"/> pain medicine    | <input type="checkbox"/> cortisone/steroids | <input type="checkbox"/> beta blockers             | <input type="checkbox"/> hormone replacements |

Please check the following conditions that you have or have had:

- |                                    |  |   |  |                                   |
|------------------------------------|--|---|--|-----------------------------------|
| <input type="checkbox"/> Anemia    | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Low blood sugar    | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Polio    |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke          | <input type="checkbox"/> AIDS     |
| <input type="checkbox"/> Cancer    | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart attack       | <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Epilepsy |

Please Describe any "Yes" answers above: \_\_\_\_\_

**Please Mark the Box related to any symptom you are CURRENTLY experiencing or HAVE Experienced Head**

- Unusually frequent headaches  Unusually severe headaches  Previous head trauma  
 Head feels heavy  Light headedness  Facial Numbness  Vertigo  Loss of balance

**Neck**

- Neck pain with movement  dizziness with neck movement  Neck feels out of place  Stiff neck  
 Swelling in neck  Muscle spasms in neck  Pinched nerve in neck  Previous neck injury

**Shoulders**

- Pain in shoulder (right or left)  Muscle spasms in shoulders  Pain across shoulders  Tension in shoulders  
 Can't raise arm over head  Can't raise arm above shoulder level

**Arms & Hands**

- Pain in upper arm  Pain in forearm  Pain in hands  Pain in fingers  Fingers go to sleep  Cold hands  
 Swollen finger joints  Sore finger joints  Loss of grip strength  Pins and needles

**Mid back**

- Pain between shoulder blades  Muscle spasms in mid back  Pain over kidney area  Mid back pain  
 Pain below shoulder blades with exercise  Pain from front to back

**Please Mark the Box related to any symptom you are CURRENTLY experiencing or HAVE Experienced**  
**Low back**

- Low back pain  Low back out of place  Muscle spasms in low back

**Hips, Legs, & Feet**

- Pain in buttocks  Pain down leg  Cold feet  Knee pain  Leg cramps  Swollen ankles  
 Sensation of pins and needles  Numbness in legs or toes  Swollen feet

**Cardiovascular**

- Chest pain  Fainting  Pounding heartbeat  Heart “jumps”  Rapid heartbeat  Irregular heartbeat  
 Blue skin  High blood pressure  Poor circulation  Heart murmurs

**Hair, Skin, & Nails**

- Baldness  Dry/Oily scalp  Allergies to Chlorine  Psoriasis  Itchy skin  Rough, scaly scalp  
 Sensitive skin  Dry or Oily skin  Yellow skin  Bruise easily  Pale skin  Rashes  Eczema  
 Skin cancer  Nail biting

**Eyes**

- Blurred vision  Double vision  Eyes fatigue easily  Excessive tearing  Lack of tearing  
 Light bothers eyes  Pain in eyeball (s)  Periods of blindness in eyes  Red eyes  Night blindness  
 Pain behind eyes

**Ears**

- Loss of hearing  Pain in ears  Discharge from ears  Vertigo  Ringing in ears

**Nose/Nasopharynx/Sinuses**

- Unusual nasal discharge  Nose bleeds  Pressure over eyes  Pressure under eyes  
 Sinusitis/Nasal allergies  Any trauma to nose

**Mouth & Throat**

- Pain in mouth  Pain in throat  Bleeding gums  Abscessed teeth  Difficulty swallowing

**Respiratory**

- Shortness of breath  Asthma  Chronic cough  Difficulty breathing  Dry cough  Wheezing  
 Difficulty sleeping while lying down  Productive cough  Coughing up blood

**Gastrointestinal**

- Poor appetite  Constant nibbling  Indigestion  Stomach upsets from food or liquid  
 Abdominal pains  Stomach upsets from medicines  Stomach gas before/after meals  
 Stomach gas with meals  Change in bowel habits  Diarrhea  Constipation  Hemorrhoids  
 Jaundice  Ulcers  Liver disease  Hepatitis  Loss of bowel control  Gall bladder disease

**Genitourinary**

- Urination is: Frequent / Infrequent? Amount is: High / Low?  Need to get up at night to urinate  
 Blood in urine  Difficult to start/stop or painful urination  Incontinence  Stream flow abnormality   
Lack of bladder control  Back pain with urination  Cloudy urine

**Female Only:** Date of last menstrual period \_\_\_\_\_

- Painful periods  Missed menstrual periods  Irregular cycles  Spotting  Vaginal discharge  
 PMS symptoms  Lumps in breasts  Wear an IVD \_\_\_ # of pregnancies \_\_\_ # of deliveries \_\_\_ # of vaginal deliveries \_\_\_ # of C-sections  Complicated deliveries  LBP w/ menses  LBP w/ pregnancy  
 Fibroid tumors  Ovarian cysts  Nipple discharges \_\_\_  Excessive menstrual flow

**Male Only**

- Impotence  Testicular swelling/pain  Testicular masses  Blood in sperm  Prostate disease

**Allergies**

**Please list all allergies** (Seasonal, Food, Medications): \_\_\_\_\_

**Family History**

Do you have any children? **Yes No** If yes, please list their sex and their ages

Do your children have any major medical problems (past or present)? **Yes No** If yes, please describe

Do you have any siblings? **Yes No** If yes, list any medical problems that are part of their history

Are your parents still living? **Yes No** Do they have any major medical problems? **Yes No**  
If yes, please describe \_\_\_\_\_

Do your grandparents have any major medical problems? **Yes No**  
If yes, please describe \_\_\_\_\_

**General Health Questions**

**Do you:**

Use tobacco products? **Yes No** If yes, What type?: \_\_\_\_\_

How Much? \_\_\_\_\_ How long? \_\_\_\_\_ Have you ever tried quitting? **Yes No**

If you quit, When? \_\_\_\_\_ Why? \_\_\_\_\_

Drink Alcoholic Beverages? **Yes No** If yes, how much do you drink per week? \_\_\_\_\_

Have a history significant for recreational drug use? **Yes No** If yes, Describe \_\_\_\_\_

**Please answer the questions below:**

My diet is  balanced  not balanced My recreation is  sufficient  insufficient.

My rest is  sufficient  insufficient My family stress is  severe  moderate  minimal  none

How do you like your work?  above average  average  below average  N/A

My job stress is  severe  moderate  minimal  none  N/A.

Thank you for completing this form. The information you have provided will help us in attending to your healthcare needs.

I have read and completed all answers to the above questions to the best of my knowledge. I understand that failure to properly disclose all appropriate health history may hinder my health care provider's ability to properly diagnose and treat my complaints. I will, on all future visits, inform my health care provider of changes in my health status.

Your signature \_\_\_\_\_ Date \_\_\_\_\_

Provider's signature \_\_\_\_\_ Date \_\_\_\_\_