# Patient History

Name: ______________________________________________ Social Security #________________________ Date ________________

Address _________________________________ City _____________________________ State ________ Zip _________________

Race (circle one)

| | | | | |
|---|---|---|---|---|
| White | Black/African American | Hispanic | American Indian/Alaskan Native | Asian |
| Asian | Asian Indian | Chinese | Filipino | Japanese |
| Korean | Guamanian or Chamorro | Samoan | Native Hawaiian or other Pacific Island | Vietnamese |

Other _____________________________ I choose not to specify

Multi-Racial: Yes ( ) No ( ) Unknown ( ) Preferred language _____________________________________________________

Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Home Phone _______________ Cell Phone _______________ Home Email ____________________Work Email ____________________

By providing my email address, I authorize my doctor to contact me via email address(es) provided

Age _______ Birthdate _______________ Sex _________ Status M S W D No. Children _______________________

Occupation ______________________________ Employer __________________________ Years Employed _____________________

Employer Address _________________________ City ______________________ State ____________ Phone ________________

Spouse's Name ____________________________ Occupation __________________ Employer ________________________________

Person Responsible for this account ___________________________________ Referred by ______________________________

What is your major complaint? ________________________________________________________________________________

_____________________________________________________________________________________________________

Other Complaints ____________________________________________________________________________________________

How Long have you had this condition? _______________ Have you had this or similar conditions in the past? _______________________

What activities aggravate your condition? ________________________________________________________________________

Is this condition getting progressively worse? Yes ( ) No ( ) Constant ( ) Comes and Goes ( )

How Long has it been since you felt really good? ____________________________________________________________

Family Medical Doctor ________________________________________ Telephone _____________________________________

Other doctor Seen for this condition ___________________________ Diagnosis _____________________________________

Treatment: Medication _________________________________________ Physiotherapy _________________________________

Results _________________________________________________________ Length of time under care _______________________

Were you off work? Yes ( ) No ( ) If yes, how long _____ Have you returned to your same job? Yes ( ) No ( ) If no, why not ______

Have you had an X-ray or CT scan or MRI of your spine in the last 28 days? Yes ( ) No ( )

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**ACCIDENT INFORMATION:** Did you accident occur while at work? Yes ( ) No ( ) Were you involved in an auto accident? Yes ( ) No ( )

Date of accident ____________ Time _________ Injury reported to employer Yes ( ) No ( ) Name of Supervisor _________________

Have you had any other personal injury or accident: Past year ( ) Past 5 Years ( ) Over 5 years ( ) None ( )

Do you have an attorney? Yes ( ) No ( ) Name and Address _______________________________________________________

__________________________________________________________________

Family History (check all that apply) ( ) Adopted or history unknown ( ) Heart Disease ( ) Cancer

( ) Tuberculosis ( ) Malignant Hyperthermia ( ) Diabetes ( ) High/Low Blood Pressure

( ) Stroke ( ) Kidney Disease ( ) DVT/Blood Clots

**MEDICATIONS** (Record al medications, dosages and frequency) ( ) None

| | Medication | Dosage | Frequency | | Medication | Dosage | Frequency |
|---|---|---|---|---|---|---|---|
| 1 | ____________ | ________ | _________ | 4 | ____________ | ________ | _________ |
| 2 | ____________ | ________ | _________ | 5 | ____________ | ________ | _________ |
| 3 | ____________ | ________ | _________ | 6 | ____________ | ________ | _________ |

**ALLERGIES** (Record all allergies and associated reaction) ( ) No known allergies

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1 | ____________ | ________ | _________ | 4 | ____________ | ________ | _________ |
| 2 | ____________ | ________ | _________ | 5 | ____________ | ________ | _________ |
| 3 | ____________ | ________ | _________ | 6 | ____________ | ________ | _________ |

**Surgical History** (Record all surgeries ad the year they occurred) ( ) No Surgical History

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1 | ____________ | ________ | _________ | 4 | ____________ | ________ | _________ |
| 2 | ____________ | ________ | _________ | 5 | ____________ | ________ | _________ |
| 3 | ____________ | ________ | _________ | 6 | ____________ | ________ | _________ |