

PATIENT HEALTH HISTORY

ame: Date of Birth:			
HISTORY OF PRESENT CO			
	-	re yourself?	
		-	
, c			_
List diagnostic tests for this			
check if no previous		,	
TEST	DATE	RESULT	
Is the pain?Cons Please fill in the appropriate Ratin Now?	t?Morning tantOn and O	NightWith Activity _ ff flow times:510 At its worst?	At rest
		WorseStayi	
Are you out of work becaus	e of this problem? Yes	sNo	
When do you intend to retu	rn to work (date)?		
	-		



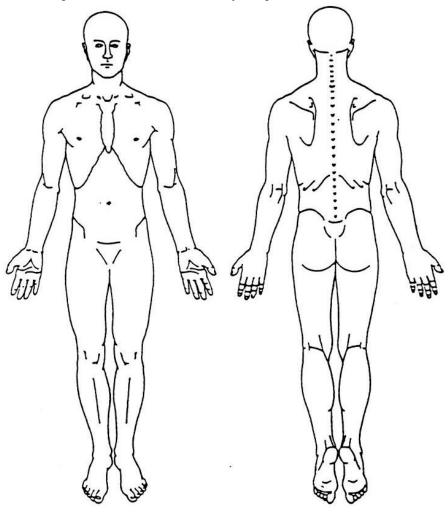
	it condition (surgery, mijec	tions, chiropractor,
splint, or brace, medication, etc.)?		
Are you planning to follow-up with the referring If so, when?	physician?Yes	No
PAST MEDICAL HISTORY Please check if you have any of the following:		
AllergiesCOPD	High Blood Pressure	Multiple Sclerosis
Visual LossAnemia _	CVA (Stroke)	HIV/AIDS
Parkinson'sOther _	Arthritis	Diabetes
	Bone Loss	GOUT
	Cancer	Hearing Loss
Liver DiseaseThyroid	•	77 l D:
Cardiac (MI, Arrhythmia, Angina)	Lupus	Vascular Disease
PAST SURGERIES		
PAST SURGERIES TYPE		DATE
TYPE 1.		DATE
TYPE 1. 2.		
1.		
TYPE 1. 2. 3. 4. Have you ever broken any bones?		
TYPE 1. 2. 3. 4. Have you ever broken any bones? Past motor vehicle accidents?		
TYPE 1. 2. 3. 4. Have you ever broken any bones? Past motor vehicle accidents? Please note any known allergies to medications:_		
TYPE 1. 2. 3. 4. Have you ever broken any bones? Past motor vehicle accidents? Please note any known allergies to medications:_ Do you wear a pacemaker?		
TYPE 1. 2. 3. 4. Have you ever broken any bones? Past motor vehicle accidents? Please note any known allergies to medications: _ Do you wear a pacemaker? Do you have any metal implants?		
TYPE 1. 2. 3. 4. Have you ever broken any bones? Past motor vehicle accidents? Please note any known allergies to medications: _ Do you wear a pacemaker? Do you have any metal implants? Are you or do you think you may be pregnant?	YesNo	
TYPE 1. 2. 3.	YesNo	



BODY DIAGRAM

INSTRUCTIONS

On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present condition.



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt

		CVCI ICIL.		
 No Pain Shade in the areas on the diagram that corres		Worst Pain Possible respond to your pain or symptoms (circle all the		at apply)
Sharp	Dull	Aching	Burning Tightness	

	Numbness	Tingling	Localized Radiating	Constant Intermittent
Patient Sign	nature:			Date: