***PATIENT HEALTH HISTORY***

***Name***_____

**Who is your primary doctor? _____ Are you on BLOOD THINNERS? Y N**

**List <u>all</u> surgeries:**
Date: _____ Type: _____
Date: _____ Type: _____
Date: _____ Type: _____

**Medications:**
Type: _____
Type: _____
Type: _____

**Do you have/had any other medical conditions?** (circle all that apply)

Heart Disease Diabetes High Blood Pressure Lung Pacemaker Hernia Dizziness
Stroke Migraine Herniated Disc Allergies_____ Cancer_____**Pregnant Y N**

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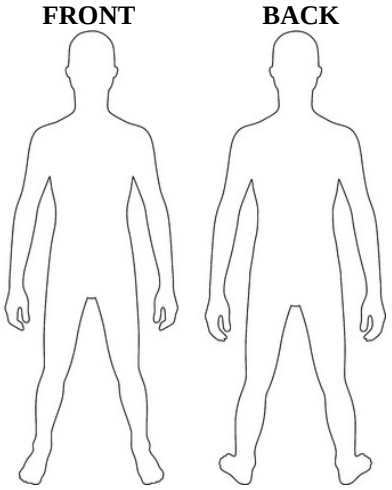
| **Chief Complaints:** | **Pain Level:** | **Pain Began:** |
|---|---|---|
| 1_____ | low 2 4 6 8 10 high | _____ |
| 2_____ | low 2 4 6 8 10 high | _____ |

**How did the pain begin?_____**

**SHADE AREAS OF PAIN**




**Quality:** (circle all that apply) occasional frequent constant dull sharp shooting
tingling burning numb spasm

**What movements increase pain?_____**

**What activities can you no longer do or have difficulty performing?**
bathing dressing driving sitting standing walking yardwork childcare stairs sports

**Previous treatment for this same condition:** Prescription Medication_____
Physical Therapy Chiropractic Trigger Point Injection Epidural OTC drugs
**Results:** Good Fair No help