

PATIENT HISTORY

NAME: _____

DATE: _____

Date of Birth: _____

AGE: _____

1. During the past 3 months have you been seen by (circle all that apply)?

Medical Doctor (MD) Chiropractor Physical Therapist Other: _____

2. Have you EVER been diagnosed as having any of the following conditions (check all that apply)?

<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Anemia
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Other Arthritic Conditions	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Stroke
<input type="checkbox"/> Dependency on drugs/alcohol	<input type="checkbox"/> Hepatitis	Other: _____
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tuberculosis	
	<input type="checkbox"/> Kidney Disease	

3. Do you presently have any of the following?

<input type="checkbox"/> Productive Cough	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Coughing up Blood	<input type="checkbox"/> Fever	<input type="checkbox"/> Lethargy/Weakness

4. **At this time would you say your health is:** _____ Excellent _____ Good _____ Fair _____ Poor

5. **Occupation:** _____ **Duties:** _____

6. **Hobbies:** _____

7. **Please list all surgeries, including year:** _____

8. **Please list any broken bones you have ever had, and when:** _____

9. **Have you received any Home Health Care in the last year?** YES NO

10. **If yes, what agency ?** _____

11. **For women: Are you pregnant?** YES NO **Are you possibly pregnant?** YES NO

12. Please rate your typical pain on the following scale:

Please draw where your pain occurs. X = pain 0 = numbness

