



# Health History Form

Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Sex M F Date \_\_\_/\_\_\_/\_\_\_ Occupation \_\_\_\_\_

Referred By \_\_\_\_\_ Primary Care Physician \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Reason for visit \_\_\_\_\_ Right Left Both

Symptoms due to Sports Accident Work related Other \_\_\_\_\_ Date symptoms began \_\_\_/\_\_\_/\_\_\_

How did injury happen \_\_\_\_\_

How severe is pain on a scale from 1 to 10 (circle number)      1    2    3    4    5    6    7    8    9    10

Are symptoms Constant Intermittent Worsening Improving \_\_\_\_\_

Associated symptoms include Stiffness Swelling Instability Weakness Numbness/Tingling \_\_\_\_\_

What makes symptoms worse? \_\_\_\_\_ Better? \_\_\_\_\_

Previous injuries to current problem? \_\_\_\_\_

What previous treatment have you tried (medications, therapy, injections)? \_\_\_\_\_

What is/are your treatment goal(s)? \_\_\_\_\_

### Medical History

#### Patient    Family Member

- HIV/AIDS
- Hepatitis
- Diabetes
- Stroke
- Asthma
- Skin Disorders
- Concussions # \_\_\_\_\_
- Heart Attack/Disease
- High Blood Pressure
- Anemia
- Osteoarthritis
- Rheumatoid Arthritis
- Osteoporosis
- Bone Infections
- Gout
- Depression
- Cancer \_\_\_\_\_
- Seasonal Allergies
- Other \_\_\_\_\_

### Current Medications

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### Medical Allergies (medicines, latex, injections)

<u>Name</u>	<u>Type of Reaction</u>
_____	_____
_____	_____
_____	_____
_____	_____

### Surgical History

<u>Procedure</u>	<u>Year</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

### Do You Have Symptoms Of

- Weight Loss    Weight Gain    Nausea/Vomiting
- Fever
- Headaches    Chest Pain
- Loss of Consciousness    Palpitations
- Dizziness    Fainting
- Weakness    Difficulty Breathing
- Fatigue    Easy Bleeding
- Skin Changes

### Social History

- Do you consume alcohol?    Yes    No    Number of drinks per week \_\_\_\_\_
- Do you smoke tobacco?    Yes    No    Number of packs per day \_\_\_\_\_ for how many years \_\_\_\_\_
- Do you participate in recreational drugs?    Yes    No    What type? \_\_\_\_\_
- Do you exercise regularly?    Yes    No    What type? \_\_\_\_\_ How often? \_\_\_\_\_

Reviewed this information with patient    Date \_\_\_/\_\_\_/\_\_\_    Date \_\_\_/\_\_\_/\_\_\_    Date \_\_\_/\_\_\_/\_\_\_    Date \_\_\_/\_\_\_/\_\_\_    Date \_\_\_/\_\_\_/\_\_\_

Notes    Date \_\_\_/\_\_\_/\_\_\_    Date \_\_\_/\_\_\_/\_\_\_    Date \_\_\_/\_\_\_/\_\_\_    Date \_\_\_/\_\_\_/\_\_\_    Date \_\_\_/\_\_\_/\_\_\_

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