Patient History – Please fill in the following questionnaire about your health to the best of your ability.

Name_____ Date: _____
Email Address: _____
Address / City_____ State_____ Zip_____
Best Phone # _____ Date of Birth_____ Age_____
Referred by_____ Social Security #_____
Occupation_____ Employer_____
Marital Status S M D W Spouse Name_____
Number of Children/Ages_____

Please circle for each of the following:

		Patient Comment If answer is yes	
Current Health Habits:			
Did/do you smoke?	Y N	_____	_____
Did/do you drink alcohol?	Y N	_____	_____
Diet, do you eat healthy foods?	Y N	_____	_____
Have you been in accidents/trauma?	Y N	_____	_____
Have you had surgery?	Y N	_____	_____
Drugs, prescription, OTC, recreational?	Y N	_____	_____
Dental problems?	Y N	_____	_____
Eye problems?	Y N	_____	_____
Hearing problems?	Y N	_____	_____
Exercise regularly?	Y N	_____	_____
Did/do you have occupational stress?	Y N	_____	_____
Drive? Daily time spent driving	Y N	_____	_____
Physical stress?	Y N	_____	_____
Emotional/Mental stress?	Y N	_____	_____
Hobbies/Sports injuries?	Y N	_____	_____
Do you sleep well, hours of sleep?	Y N	_____	_____
Sleeping posture? O side O stomach O back		_____	_____

Symptoms and Present State of Health

Present Complain_____

Pain or Problem started on_____

Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other_____

Does this pain shoot, radiate, or travel in your body? Where? _____

Are you experiencing numbness or tingling in any area of your body? Where? _____

Since it began, is it: O Same O Better O Worst

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

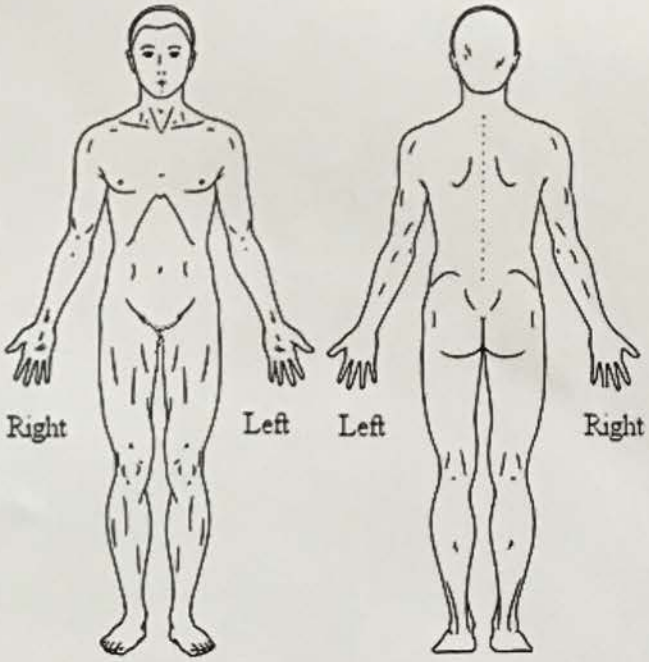
Is this condition worse during certain times of the day? _____

Is this condition interfering with Work? _____ Sleep? _____Routine? _____Other? _____

Is this condition progressively getting worse? _____

Other Doctors seen for this condition_____

Please Circle where you are at: (NO Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain)
Using the symbols below, mark on the pictures where you feel pain.



Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +

Please mark any of the following conditions or symptoms that you have now or have experienced:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	**O High Blood Pressure (uncontrolled)**
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Pacemaker	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause
O History of Epilepsy	**O Uncontrolled Atrial Fibrillation**	**O Implanted Brain Stimulator**

Are you under medical care for any condition? _____

What Medications are you taking? _____

Have you had surgery? _____ Type? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

Females Only - Are you possibly Pregnant?_____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform our office of any changes in my health.

Patient Signature_____ Printed Name_____ Date_____