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# Patient Medical History

Check all that apply: □ None apply

□ Osteoarthritis □ Depression □ High Blood Pressure □ Diabetes □ Kidney Failure
□ Anemia □ Migraines □ Seizures □ Heart Attack □ Osteoporosis
□ Blood Clot(s) □ Liver Disease □ Stroke □ Cholesterol □ Cancer: _____
□ Lung Disease □ Heart Failure □ Chronic Pain □ Asthma □ Rheumatoid Arthritis

**Medication Allergies** (Food, Latex): □ No Known Drug Allergies

_____

## Past Surgical History:

| Type of Surgery | Approx. Year | Type of Surgery | Approx. Year |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

## Pharmacy Information

Pharmacy Name: _____ Phone#: (____) ____-_____ Location: _____

List **ALL CURRENT** Medications and doses: □ None

| | | | |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Do you smoke? □ Yes □ No _____ packs/day for ___ years Do you drink alcohol? □ Yes □ No
□ Quit ____ months/years Do you dip/chew tobacco? □ Yes □ No □ Daily □ 1-2 x/week □ Occasional

## Family History

**Check all that apply**: □ None apply □ Deceased □ Mother (M) _____ □ Father (F) _____
□ Stroke M/F □ Diabetes M/F □ Seizures M/F □Heart Disease M/F □ High Blood Pressure M/F
□ Mental Illness M/F □ Arthritis M/F □ Gout M/F □ Cancer M/F _____ □ Bleeding Disorders M/F

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**Chief Complaint:** □ Neck Pain □ Back Pain □ Leg pain □ Arm pain □ Other_____

On what date did your symptoms start? _____

Symptoms described as: □ Sharp □ Dull □ Achy □Burning

□ Spasms □ Other _____

Do your symptoms interfere with your daily activities? □ Yes □ No

Is your condition the result of a Work Injury? □ Yes □ No Auto Accident? □ Yes □ No

Was there a trauma or inciting incident? _____ Date of injury? _____

1. Arm symptoms: □ Pain □ Numbness □ Weakness □ Right Arm □ Left Arm
   Leg symptoms: □ Pain □ Numbness □ Weakness □ Right Leg □ Left Leg
2. Do you have problems with balance or frequent falling/tripping? □ Yes □ No
   Pain is: □ Improving □ Worsening □ Same (unchanged) □ Other: _____
3. Activities that worsen your pain: □ Sitting □ Standing □ Walking □ Lying Down
   □Bending/twisting □ Other_____
4. Activities that relieve your pain: □ Sitting □ Standing □ Walking □ Lying Down
   □Bending/twisting □ Other_____
5. How many minutes can you stand/walk before you need to rest?
   □ less than 5 □ less than 30 □ less than 60 □ 60 or more □ Other: _____

**Treatments Include:**

□ **NONE** (no medications, physical therapy, chiropractic manipulations, injections or bracing)

□ Anti-inflammatory medication □ Physical Therapy □ Acupuncture □ Oral steroids □ Bracing

□ Muscle relaxants □ Acupuncture □ Chiropractic Manipulation □ Narcotic/Opioid pain medication

**Injections:** □Trigger Point □ Epidural Steroid □ Facet □ Sacroiliac

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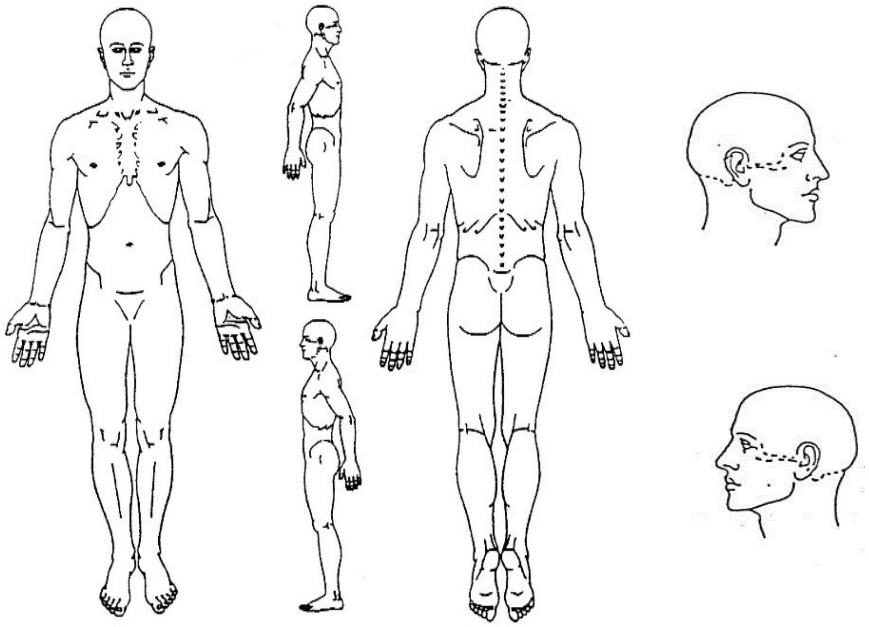

Please mark the area of discomfort by using the appropriate letter(s).

X = Pain B = Burning

T = Tingling W = Weakness

On a PAIN SCALE of 1- 10 what number would you consider yourself?

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10