

CONFIDENTIAL PATIENT MEDICAL HISTORY

Name:

Date:

Describe injury or events leading to onset of symptoms/pain: _____

Please indicate your pain levels: Least: _____ Worst: _____
(0 = Pain Free to 10 = Worst)

What activities increase pain? (I.E., rising from sitting, walking, bending, etc.): _____

What activities decrease pain? (I.E., lying down, use of heat, etc.): _____

Is there any numbness? Yes No Where? _____

Do symptoms radiate to other body parts? Yes No Where? _____

How often do you wake at night due to pain? _____

Are medications being taken **for this condition**? Yes No (If yes, name all that apply)

Anti-inflammatory: _____ Pain Pills: _____

Muscle Relaxants: _____ Other: _____

What other medications are being used and for what condition(s)? _____

Have any of the following been performed **for this condition**?

X-rays Body Part: _____ Date: _____

CT Scan/MRI Body Part: _____ Date: _____

Previous Surgery Body Part: _____ Date: _____

Please mark if you had or currently have problems with any of the following:

Pace Maker Infections Bowel/Bladder

Heart Attack Diabetes Metal Implants

Headaches Cancer Dizziness

Stroke Hernia High Blood Pressure

Heart Disease FEMALES ONLY: Pregnant: Yes No

Is there anything else we need to know about your health? _____
