**PERSONAL HEALTH HISTORY**- To be completed by Patient Prior to Office Visit

**Please be advised** that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Chadfield will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and **whether the practice will accept you as a patient.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Middle Initial

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of First Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your Primary Care Physician?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list who referred you to this clinic?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mark the areas on your body where you feel pain now or regularly

Use the appropriate codes indicated below.

ACHE >>>> NUMBNESS --------- PINS & NEEDLES 000000 BURNING xxxxx STABBING //////

 >>>> --------- 000000 xxxxx //////

 >>>> --------- 000000 xxxxx //////



 What number is your pain at worst \_\_\_\_\_\_\_\_ when best \_\_\_\_\_\_\_\_ today \_\_\_\_\_\_\_\_\_\_\_(0 no pain/10 worst pain)