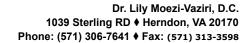




## **Confidential Patient History**

Patient	Date: DOB:	
Address:		
Email:		
Height: Wei	ight: Referred by:	
Major complaint and symptoms	s:	
How do you believe your probl	lem (pain) began?	
When did you first notice this p	problem/pain?	
Which positions or activities ag	ggravate your condition?	
Which positions or activities re	lieve your condition?	
Have you ever been treated by If yes, where?	y any other physicians for this ailment? Y	es / No
Diagnosis of previous physicia	n	
Length of time under care	Results	
	General Health Questionnaire	
Do you have vertigo		
		Yes / No
Do you pass out easily (faint o	r loss of consciousness)?	Yes / No
	nave you lost sight in one eye?	
	ch or difficulty with speech?	
	iculty swallowing?	
	king, with coordination or falling to one side?	
	ng?	
	e side of your face or body?	
	pances or rapid eye movement?	
Do you have or have you ever	had difficulty in arranging words properly? .	Yes / No
	ead pain that is unlike any you have had bef	
	ours or days?	
	e in your family?	
Do you have a sore that does	not heal?	Yes / No
	ding or discharge?	
	or hoarseness?	
Do you have night sweats?		Yes / No
Do you have pain in the neck,	jaw or face?	Yes / No
Do you have a drooping eyelid	or change in your pupils?	Yes / No
	ur ears?	
	from a sound sleep?	
	without trying?	
	der or bowel control?	
	or had double vision recently?	
Do you take birth control pills?		Yes / No





Are you taking any prescription medications?
Are you taking herbs, supplements, botanicals, or vitamins?
Are you taking any medication or overthecounter drugs? (aspirin, etc.)
Are you seeing any other doctor now for any reason?
(Women only) Do you have any reason to believe that you may be pregnant? Yes / No What operations have you had? Please include cosmetic surgery, etc.  Year
Year
SOCIAL HISTORY
Smoker?Yes / No If yes, how many packs a day? Years?
Alcohol?Yes / No
If yes, how much? Years?
FAMILY HISTORY
Did your mother or father have any of the following: Put an M for mother, F for father, and B for both.  High Blood Pressure Ulcer or Stomach Problems Heart Attack (At what age) F: M: Stroke (At what age) F: M: Emphysema Seizure/Convulsions Arthritis HIV Positive Mental Illness Asthma Thyroid Disease Diabetes Circulation Problems Kidney Disease Cancer
Are you currently being treated or have you ever been treated for ANY condition not listed above? Please list the conditions and treatment:
Patient signature: Date: