
PATIENT HISTORY HEALTH QUESTIONNAIRE

Name: _____ Today's Date: ____/____/____

Email: _____ Ht: _____ Wt: _____

Date of Birth: ____/____/____ Age: _____ Sex: Male _____ Female _____

Is your problem related to a work injury or accident? _____ Yes _____ No What is
your current complaint? _____

Have you had issues with your neck or back prior to this accident? _____ Yes _____ No

Date of injury or onset of symptoms: ____/____/____

Is there possibility that you are pregnant? _____ Yes _____ No

PERSONAL HISTORY OF:(Circle all that apply) __Diabetes__ Glaucoma __High Blood Pressure

__Heart Disease__ Stroke__ Sinus Pain __Osteoporosis__ Mitral Valve Prolapse__ Irreg Heartbeat__

Blood Clots__ Raynaud's __Asthma__ Tuberculosis__ Pneumonia __Sleep Apnea__ Kidney

Stones__ HIV or AIDS __Sickle-Cell__ Ulcer Disease __Thyroid __Kidney stones__

Cancer/type _____ Other _____

LIST CURRENT MEDICATIONS: Include prescriptions, over-the-counter, and herbal medications.

KNOWN DRUG ALLERGIES: __ No __ Yes, list _____

Past Surgical History: Operation and year

FAMILY MEDICAL HISTORY:

Who, if anyone, has or has had any of the following:

Diabetes: _____ High Blood Pressure: _____

Heart Disease: _____ Cancer _____

Stroke: _____

SOCIAL HISTORY: tobacco use: Never _____ Previously, but quit _____ Packs per day _____

Alcohol use: Never _____ Rarely _____ Moderately _____ Daily _____ History of Alcoholism _____

Illegal or street drugs: Never _____ Type/Frequency _____ History of Abuse _____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Occupation: _____ Duties: _____

Retired _____

IF ACCIDENT OR INURY: Are you working? YES or NO Restrictions? YES or NO

If no, last day worked? _____ Does your employer have light duty? YES or NO or UNKNOWN

Have you been injured on the job before? YES or NO If yes, body part? _____

Are you on any special diet? _____

Do you CURRENTLY exercise? YES or NO If yes, what type and how many times per week? _____

Hobbies: _____ Sports: _____

Name, phone #, and address of your MEDICAL DOCTOR: _____

Name, phone #, and address of your PHARMACY: _____

MEDICAL HISTORY:

Medical Tests Already Done: ____X RAYS ____MRI ____CAT SCAN ____BONE SCAN

____MYELOGRAM ____EMG / NCS OTHER: _____

If so, have you seen any other doctor for this problem? (List below)

What type(s) of treatment(s) have you received for your back or neck?

What aggravates or makes your pain worse? (Circle all that apply)

During Exercise	Stress	Bending Forward	Damp Weather
After Exercise	Sex	Bending Backward	Cold Weather
Sitting	Coughing Morning	Fatigue	
Standing	Sneezing Night	Touching Skin	
Walking	Twisting	Work Activities	Other

What relieves or lessens your pain? (Circle all that apply)

Lying Down	Heat/Massage	Injections	Alcohol
Sitting	Medications	Exercise	Ice
Standing	Walking	Physical Therapy	Nothing

Other _____

What activities of daily living can you do now? (Circle all that apply)

Drive	Housework	Work at a Job	Climb Stairs	
Walk	Sit	Stand	Get Dressed	Yard Work

(Circle all that apply)

REVIEW OF SYSTEMS:

General/Constitutional: --fever—chills—fatigue—night sweats—weight gain—weight loss

ENT:

Tooth/Gum Trouble—difficulty hearing—sinus problems—ringing in ears

OPHTHALMOLOGIC:

Changes in vision

MUSCULOSKELETAL:

neck pain—mid back pain—low back pain—joint pain/swelling—weakness—arthritis--
fibromyalgia

CARDIOVASCULAR:

Chest pain—high blood pressure—leg pain with exercise

RESPIRATORY:

Asthma—difficulty breathing—cough—wheezing—

GENITOURINARY:

Blood in urine—difficulty urinating—painful urination—nocturia—sexual dysfunction

HEMATOLOGY:

Anemia—easy bruising—swollen glands

NEUROLOGIC:

Coordination loss—dizziness—headache—memory loss—tingling/numbness

PSYCHIATRIC:

Depression—sleeping disorder—anxiety

GASTROINTESTINAL:

Abdominal pain—blood in stool—constipation—diarrhea—heartburn/indigestion—
nausea/vomiting(not caused by flu)—Irritable bowel syndrome

ENDOCRINE:

Thyroid disorder—excessive thirst—frequent urination

SKIN:

Itching--rash

PAIN INTENSITY RATING

On the line below, CIRCLE your AVERAGE PAIN over this last week.

No Pain

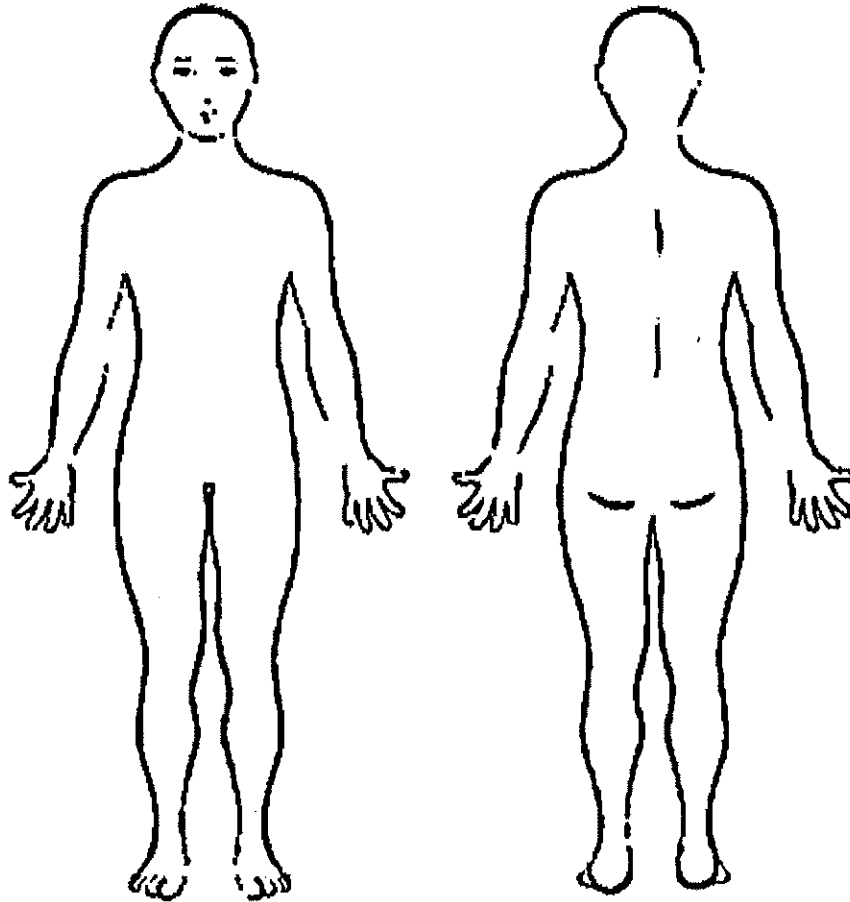
Worst Possible

0% 10 20 30 40 50 60 70 80 90 100%

WHERE IS YOUR PAIN NOW?

Use appropriate symbols shown below to mark the areas on your body where you feel these described sensations. Include ALL areas affected by your pain, and mark the type and area of pain if it radiates or spreads to other areas.

- Burning **X**
- Numbness **O**
- Pins/Needles **=**
- Stabbing **/**
- Ache **A**



Physician Initials: _____ Date: _____