Initial Medical History Intake Form

Name____________________ **Age** ____ **Handedness:** Right / Left **Today's Date**____/____/____
Date of Birth ____/____/____ **Referred By:**______________

What problem/issue brings you here today?

How and when did it start?

List 3 activities you are now unable to do:

What makes it *worse*?

What makes it *better*?

What do you want to accomplish from today's visit?

Is this a Worker's Compensation Claim or is there litigation pending?	Yes	No			
What diagnostic tests have you had for this problem?	X-ray	MRI	CT scan	EMG	Bone scan
What treatments have you had for this problem?	Massage	Injections	Physical Therapy	Psychological	Chiropractic

Please make a *mark on the line* below to indicate the level of discomfort you have today.

No Pain ______________________________ Worst Pain Ever

0 1 2 3 4 5 6 7 8 9 10

Please describe what the pain feels like: Dull, Achy, Burning, Stabbing, Numbness, Tingling, Pulling, Cramping, Tightness

Please describe the time course of your pain: Constant, Comes and goes, Getting worse, Getting better, Staying about the same

Medications (Current) *With Doses*: *ALL* medications including Prescription, Over-the-Counter (ie: Advil, Vitamins)

Medical/Surgical History: *ALL* Surgeries, Diabetes, Cancer, High blood pressure, Heart attack, Pacemaker, Arthritis, Fractures, Accidents, Osteoporosis, etc.

Allergies to medicines:

Family History: Cancer, Heart disease, Stroke, Arthritis, Osteoporosis, etc.

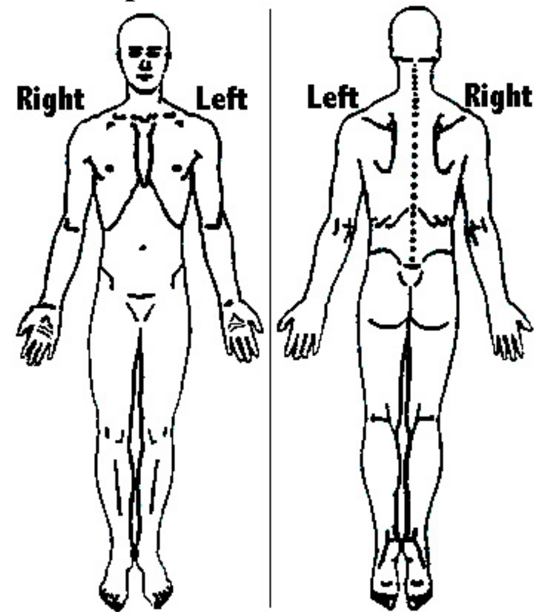
What do you do for exercise?

Do you use a cane or walker?

Tobacco use (cigarette, cigar, pipe, chew):	Current	Quit	Never
Illicit drug use (cocaine, marijuana, heroin, etc):	Current	Quit	Never
Opioid use (hydro/oxycodone, morphine, etc):	Current	Past	Never
History of substance abuse/addiction?	Current	Past	Never
Number of alcoholic beverages per week?			

Occupation:

Please draw where you have pain or discomfort



Employment status:	Full-time	Part-time	Light Duty	Off Duty due to injury	Full-time Parent	Not working	Retired

IF YES TO ANY OF BELOW, PLEASE CIRCLE SYMPTOM

- **Night pain** **Fevers** **Unintentional weight loss**
- **Vision change** **Double vision**
- **Difficulty swallowing** **Headaches**
- **Chest pain** **Palpitations**
- **Shortness of breath** **Wheezing** **Coughing**
- **Nausea** **Vomiting** **Black stools** **Loss of control of stools**
- **Loss of control of urine** **Urinary frequency** **Urinary urgency**
- **New rashes** **Psoriasis**
- **Dizziness** **Weakness** **Numbness** **Tingling**
- **Depressed mood** **Suicidal thoughts** **Sleep problems** **Anxiety**
- **Low back pain** **Joint pain** **Joint swelling** **Muscle pain**