

**PLEASE UPDATE FOR OUR RECORDS:
PATIENT HISTORY FORM**

This is a confidential record and information contained here will not be released without your consent.

Today's Date ___/___/___ Date of Injury ___/___/___ Date of Birth ___/___/___

Last Name _____ First Name _____ Middle _____

Primary Care Physician _____ Who referred you to us? _____

Do you want a report sent to this physician? _____ yes _____ no

CHIEF COMPLAINT: What is the main reason for your visit today? Describe problem in detail. (What Hurts)

Work related? _____ Sports related? _____ Motor Vehicle Accident? _____

HISTORY OF PRESENT ILLNESS

When did you first notice this problem? _____

What makes the problem worse? _____

What makes the problem better? _____

How long does the problem usually last?

Minutes _____ Hours _____ Constant _____ Occasional _____

Does the problem interfere with your normal functions? (Explain) _____

Have you seen another physician for this problem? (Explain) _____

Have you had any diagnostic studies or treatments for this problem? (X-rays, MRI, EMG, Bone Scan, Bone Density?) If so, when and where? _____

Pain Level _____ 0-3 (mild) _____ 4-6 (moderate) _____ 7-10 (severe)

List any changes in medical history in the last 6 months (**DIAGNOSIS, MEDICINES, or SURGERIES**):

List all known drug allergies: _____

Signature _____