PATIENT HEALTH HISTORY

Today's Date: _______________
Patient Name: ____ Date of Birth: _______________

Patient Height _______________ Patient Weight _________________

Chief Complaint

Reason for today's visit? ____

Has Physical therapy been initiated? ☐ Yes ☐ No
Facility___________________ Phone Number_____________________

Have other Conservative treatments (i.e Injections, chiropractic) been ordered? ☐Yes ☐No
If Yes, Please list: ____

Current problem is the result of a(n): Check all that apply
☐ Car Accident ☐ Work Accident ☐ Accident ☐ Other ________________________________
Date of onset _______________________

Past Medical History

Please list any medical conditions (i.e hypertension, diabetes, etc) or major injuries: ____________
____
____
____

Surgeries/Hospitalizations	Year	Complications

Have you ever had an antibiotic resistant infection? ☐ Yes ☐ No
If Yes, was it MRSA (Methicillin Resistant Staphylococcus Aureus) or VRF (Vancomycin Resistant Enterococcus)? (Please circle)

Have you ever had problems with anesthesia? ☐ Yes ☐ No
Do you take Aspirin? ☐ Yes ☐ No If Yes, how often : __________________________

Current Medications **Including Over the Counter**	Dose	Frequency

Today's Date: _______________
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ALLERGIES/TYPES OF REACTIONS
Please circle: **Latex** Yes No **Iodine** Yes No **Shellfish** Yes No **Asthma** Yes No

Family Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

SOCIAL HISTORY

Do you have children? ☐ Yes ☐ No How many? __________________

Do you live alone? ☐ Yes ☐ No Who lives with you? ___________________________________

Do you smoke? ☐ Yes, I've smoked _______ packs of cigarettes per day for _____________ years.
☐ Yes, I smoke cigars or a pipe.
☐ No, I have never smoked.
☐ No, I quit ______ years ago. At that time I was smoking ______ packs per day for ______ years.

Do you drink alcohol? ☐ No, never (or rarely) ☐ No, but I used to
☐ Yes ☐ Daily ☐ 1 or more times a week ☐1 or more times a month

Are you at risk for AIDS (e.g., sexual orientation, drug abuse, previous blood transfusion)?
☐ No ☐ Yes, please explain ____

☐ Deferred by patient: Signature ____