NEW PATIENT HISTORY

Date: _____ **SSN:** _____

Name: _____ **DOB**: _____

Address: _____
Street City State Zip

Cell Phone: ( ) _____ **Gender:** ☐ Male ☐ Female

Home Phone: ( ) _____ **Email:** _____

Employment: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Homemaker

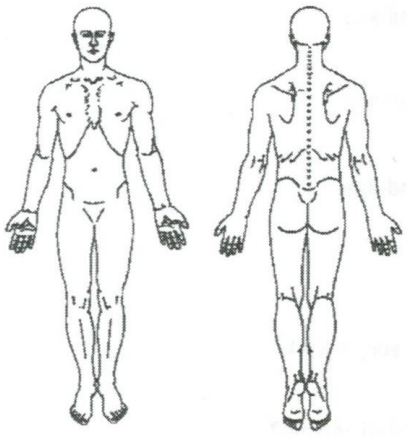
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you have Health Insurance? ☐ No ☐ Yes Height: _____ Weight: _____ lbs.

What are we seeing you for today? (Main Complaint)

- ☐ low back pain
- ☐ mid back pain
- ☐ upper back pain
- ☐ neck pain
- ☐ shoulder pain R/L
- ☐ other _____
- ☐ headaches
- ☐ hip pain R/L

1. **Location** (Where does it hurt?)
Circle the area (s) on the illustration



2. **Quality of symptoms** (what does it feel like?)

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramps
- ☐ Nagging
- ☐ Sharp
- ☐ Burning
- ☐ Shooting
- ☐ Throbbing
- ☐ Stabbing
- ☐ Annoying
- ☐ other

3. **Severity** (How extreme are your current symptoms)

0 1 2 3 4 5 6 7 8 9 10
absent uncomfortable agonizing

4. **Radiation** (Do you have pain radiating, shooting, or traveling to other parts of your body?)

- ☐ Pain radiates to _____
- ☐ Numbness/Tingling to _____
- ☐ Burning radiates to _____

5. **Do you know what caused this pain?** ☐ exercise ☐ fall ☐ trauma ☐ car accident ☐ bending over ☐ housework ☐ lifting ☐ running ☐ sleeping wrong ☐ sports injury ☐ standing too long ☐ turning ☐ twisting ☐ work related activities ☐ yard work ☐ sneezing ☐ coughing ☐ unknown ☐ picking/playing w/children ☐ old age/old problem ☐ carrying something heavy ☐ sitting too long ☐ tripping ☐ a slip ☐ a simple fall ☐ other _____

Name: _____

6. **How long has this been bothering you?** ☐ <1 day ☐1-3 days ☐ 4-7 days ☐ 1 week ☐ 1-2 weeks
☐ 2-3 weeks ☐ 1 month ☐ 2-3 months ☐ 4-5 months ☐ 6-7 months ☐ 7-11 months ☐ 1 year
☐ 1-2 years ☐ 2-4 years ☐ 5-9 years ☐ 10+ years

7. **Setting** (When is it the most noticeable?)
☐ Infrequent (less than daily) ☐ Occasional (25-50% of the time) ☐ Intermittent (50-75% the time)
☐ Frequent (75-90% of the time) ☐ Constant (90-100%)

8. **Aggravating or relieving factors** (What make it better or worse, such as time of day, movements, certain activities, etc)

What tends to **WORSEN** the problem? ☐ Sitting ☐ Standing ☐ Walking ☐ Lying down
☐ Getting up ☐ Lifting ☐ Twisting ☐ Looking down ☐ Looking up ☐Looking right
☐Looking left ☐ Bending Other _____

What tends to **LESSEN** the problem? ☐ Rest ☐ Ice ☐ Heat ☐ Sitting ☐ Lying down
☐ Standing ☐ Walking ☐ Stretching ☐ Leaning to a side ☐ Medication ☐ Nothing
☐ Other _____

9. **Prior intervention** (What have you done to relieve the symptoms?) ☐ Rx medication ☐ OTC medication
☐ Ice ☐ Heat ☐ Massage ☐ Chiropractic ☐ Surgery ☐ Nothing

10. **Are there any other complaints?** (Check all that apply)
☐ low back pain ☐ neck pain ☐ headaches
☐ mid back pain ☐ shoulder pain R/L ☐ hip pain R/L
☐ upper back pain ☐ other _____

11. **Do you have any previous ILLNESS or MEDICAL PROBLEMS that we need to know about?**

☐ High Blood Pressure	☐ High Cholesterol	☐ Diabetes	☐ Heart Problems
☐ Pacemaker	☐ Migraines	☐ Anemia	☐ Arthritis
☐ Asthma	☐ Cancer	☐ Emphysema	☐ Epilepsy
☐ Gout	☐ Kidney Disease	☐ Hernia	☐ Herniated Disc
☐ Liver Disease	☐ Osteoporosis	☐ Stroke	☐ Rheumatoid Arthritis
☐ Thyroid Problems	☐ Multiple Sclerosis	☐ Other _____	

12. **Please list any surgeries that you have had:** _____
_____

13. **Current Medications**: _____
_____

14. **Do you have any allergies:** _____
_____

15. **Please list any previous car accidents, serious falls, or traumas:** _____
_____

16. **Do you have a Family History of:**

☐ Diabetes	☐ Heart Disease	☐ Cancer	☐ Stroke
☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Osteoporosis
☐ Arthritis	☐ Rheumatoid Arthritis	☐ Other _____	

Name: _____

17. **Social History** (Please tell us about your health habits and stress levels)

Alcohol use	☐ Never	☐ Occasionally	☐ Frequently	☐ Daily
Tobacco Use	☐ Never	☐ Former	☐ Current	
Caffeine use	☐ Never	☐ Occasionally	☐ Frequently	☐ Daily
Exercise	☐ Never	☐ Daily	☐ Occasionally	☐ Frequently ☐ a few times/week

18. **Are you currently experiencing any of the following?** (Check all that apply)

☐ Neck Pain	☐ Headaches	☐ Lightheadedness	☐ Changes in Appetite
☐ Upper Back Pain	☐ Migraines	☐ Ringing in Ears	☐ Changes in Bowel Habits
☐ Mid Back Pain	☐ Dizziness	☐ Fainting Spells	☐ Constipation
☐ Lower Back Pain	☐ Stiffness in Neck	☐ Memory Confusion	☐ Diarrhea
☐ Shoulder Pain	☐ Facial Pain	☐ Numbness/Tingling	☐ Heartburn
☐ Arm/Hand Pain	☐ Grinding Teeth	☐ Seizures	☐ Nausea
☐ Knee Pain	☐ Jaw Clicks	☐ Tremors	
☐ Feet/Leg Pain	☐ Head Injury	☐ Weakness	☐ Anxiety
☐ Muscle/Joint Pain	☐ Hoarseness	☐ Vision Blurriness	☐ Depression
☐ Redness of Joints	☐ Lumps in Neck	☐ Loss of Strength	☐ Memory Loss
☐ Stiffness of Joints	☐ Sore Throat		☐ Confusion
☐ Swelling of Joints	☐ Swollen Glands	☐ Calf Pain w/walking	☐ Nervousness
		☐ Cold hands/feet	☐ Stress
☐ Cold Intolerance	☐ Frequent Urination	☐ Bruise easily	☐ Easily Irritated
☐ Dry Skin	☐ Heat Intolerance	☐ Leg Cramping	
☐ Excessive Thirst	☐ Excessive Sweating		

19. **Is there anything else we should know about your current condition, your progress or ways your condition is affecting your life?** _____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

If the patient is a minor child, print child's full name: _____

_____ _____

Signature Date

How did you hear about us?

- ☐ Grant County News
- ☐ Grant County Express
- ☐ Friend or Family Member
- ☐ Other: _____