HEALTH HISTORY QUESTIONNAIRE

Personal Information

Today's Date:_____

Name: ☐ F ☐ M		DOB:
Primary Care Provider:	Address:	
Referring Provider:	Address:	
Pain Management Provider:	Address:	
Specialty Provider:	Address:	
For what problem are you requesting a consultation:		
Is this related to a motor vehicle or work-related injury? ☐ Yes ☐ No		
If "Yes" to above, please provide the name & contact info for your attorney and/or workers compensation representative: Name:_____ Email:_____ Address:_____ Phone:_____		
Have you been treated for this problem in the past and if so by whom:		
Which of these have you tried for this problem: ☐ PT: Name and address: ☐ Chiropractic: Name and address:		

Social History

Work status: ☐ Employed_____ ☐ Disabled ☐ Unemployed ☐ Retired Tobacco use: ☐ Never smoked ☐ Former Smoker, quit use_____ ☐ Every day smoker: ppd/years _____ Alcohol use: ☐ No ☐ Yes	
Current Height: _____	**Current Weight:** _____

Current Medications *list prescription medications as well as non-prescription meds and vitamins/supplements*

Preferred Pharmacy:		
Drug Allergies: ☐ None		
Medication	Strength/Dose	Frequency

Past Medical History

Name:_____

☐ High Blood Pressure	☐ Diabetes	☐ Asthma	☐ Neuropathy
☐ Heart Failure	☐ Fibromyalgia	☐ Seizure	☐ Headaches
☐ Angina/chest pain	☐ RSD	☐ Stroke	☐ Fibromyalgia
☐ Coronary Artery Disease	☐ Rheumatoid Arthritis	☐ Brain Tumor	☐ Hepatitis
☐ Irregular Heartbeat	☐ Gout	☐ Memory Problems	☐ HIV/AIDS
☐ Valve Replacement	☐ GERD	☐ Alzheimer's	☐ Tuberculosis
☐ High Cholesterol	☐ Blood Clots	☐ Dementia	☐ Kidney Disease
☐ Heart Attack	☐ Bleeding Disorder	☐ Parkinson's Disease	☐ Cancer
☐ Sleep Apnea	☐ Emphysema/COPD	☐ Anxiety/Depression	☐ Other:

Family History

Disorder	Family Member
☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Coronary Artery Disease ☐ Stroke ☐ Bleeding Disorder ☐ Blood Clots ☐ Heart Attack	

Surgical History

Surgery	Date	Doctor/Facility

Review of Systems What symptoms are you currently experiencing?

☐ Fever	☐ Shortness of breath	☐ Headache
☐ Weight loss	☐ Stomach pain	☐ Numbness location:
☐ Weight gain	☐ Nausea/Vomiting	☐ Weakness location:
☐ Vision changes	☐ Constipation	☐ Other symptoms you are experiencing:
☐ Hearing problems	☐ Diarrhea	
☐ Chest pain	☐ Muscle pain/ache	
☐ Heart palpations	☐ Neck pain	
☐ Cough	☐ Back pain	

Patient Signature or Legal Guardian Signature:_____ Date:_____