

Patient History Form Page One

Patient Name _____

Date _____

What medical concerns can we assist with today?

Primary care physician: _____ Primary's phone # _____

Referring provider: _____ Provider's phone # _____

Pharmacy Name/Address _____ Pharmacy phone # _____

Are you currently receiving physical therapy? (Y/N)

Handedness? (Right/Left)

Are you allergic to any medications? Y Yes Y No

If yes, to which medications and what type of reaction? _____

Are you allergic to any foods? Y Yes Y No

If yes, to which foods, and what type of reaction? _____

Do you have any environmental allergies? Y Yes Y No

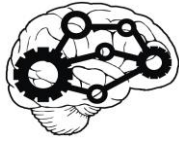
If yes, to what and what type? _____

Current Medications

| Medication | Dose (mg/mcg) | Number of times taken daily |
|------------|---------------|-----------------------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Family History

| | Living | List Illnesses: |
|----------------------|---|-----------------|
| Mother | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Father | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Sisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Brothers | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Children | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Other Family Member: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Other Family Member | <input type="checkbox"/> Yes <input type="checkbox"/> No | |



Patient History Form Page Two

Patient initials _____

Social History

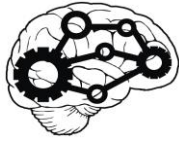
Do you currently smoke or chew tobacco? Yes No
 If yes, how many packs per day? _____ How many years have you been smoking? _____
 If no, have you in the past? Yes No How many years did you smoke? _____
 Do you drink alcohol, beer, or wine? Yes No
 If yes, how many years have you or did you drink? _____
 If no, have you in the past? Yes No How many drinks per week? _____
 Have you ever used an illicit drug? Yes No If yes, what have you used? _____

 If you still use, do you feel this is a problem Yes No
 Do you currently drink coffee, pop, tea, or energy drinks? Yes No
 Do you exercise daily/weekly? Yes No
 Do you feel you have social support Yes No
 What is the highest education level you have completed? _____
 What do you do for a living? _____
 What are your domestic responsibilities? _____
 What are your hobbies/recreational activities? _____

Please list your past surgeries

Check Yes or No to the following diagnoses if you have ever been diagnosed with them:

| | | | | | | | | |
|-------------------------|-----|----|---------------------------------------|-----|----|--------------------------------|-----|----|
| ADD/ADHD | Yes | No | Developmental or Behavioral disorders | Yes | No | Nasal Polyps | Yes | No |
| AIDS/HIV | Yes | No | Diabetes | Yes | No | Other mental health conditions | Yes | No |
| Amnesia | Yes | No | Difficulty Swallowing | Yes | No | Schizophrenia | Yes | No |
| Anxiety | Yes | No | Eating Disorder | Yes | No | Seizures | Yes | No |
| Asthma | Yes | No | Fibromyalgia | Yes | No | Sleep Apnea | Yes | No |
| Auditory Hallucinations | Yes | No | GERD/Reflux | Yes | No | Stroke | Yes | No |
| Brain Injury | Yes | No | GI Problems | Yes | No | Thyroid disease | Yes | No |
| COPD | Yes | No | Headaches/Migraines | Yes | No | Tourette syndrome | Yes | No |
| Cancer | Yes | No | Heart Problems | Yes | No | Vision problem | Yes | No |
| Chronic Ear Infections | Yes | No | Hospitalizations | Yes | No | Visual Hallucinations | Yes | No |
| Depression | Yes | No | Learning Disorders | Yes | No | | Yes | No |



Patient History Form Page Three

Patient initials_____

Circle any symptoms you have experienced in the last 2 WEEKS ONLY (current symptoms only):

| | | | | | | | |
|------------------------------|---------------------|---------------------|----------------------------|--------------------|----------------|----------------|---------------------------------|
| Difficulty Hearing | Chills | Weight Gain | Weight Loss | Dry Eyes | Vision Changes | Eye Irritation | Blurry Vision |
| Double Vision | Fever | Trouble Swallowing | Frequent nose bleeds | Dental concerns | Chest Pain | Palpitations | Known Heart Murmur |
| Hallucinations | Wheezing | Shortness of Breath | Coughing up blood | Abdominal pain | Vomiting | Diarrhea | Blood in stool |
| Urinary frequency | Pain with urinating | Incontinence | Blood in urine | Muscle Aches | Joint Pain | Joint Swelling | Rashes |
| Recent loss of consciousness | Headache/Migraine | Tremor | Seizure | Cough | Fatigue | Depression | Anxiety |
| Panic Attacks | Self-Harm | Thoughts of Suicide | Thoughts of harming others | Sleep disturbances | Restless sleep | Dizziness | Feeling unsafe in relationships |

Is there anything else you would like us to know regarding your medical history?

What are your main goals with coming to see us?
