Adult Patient History Form

Name: ____ Local Phone # ______________________

Local Address __________________________________ Email: ____________________________

Do you have any barriers to learning? Yes/ No If yes, please explain: ___________________________

Gender: M / F
Date of birth:

Smoker: Yes / No

Pregnant: Yes / No

Occupation/major:

How would you rate your general health? Excellent Good Fair Poor
Do you exercise at least 3 times/week? Y / N

Past surgeries: (list & date)_______________________________________

____

Current medications (prescription, over-the-counter):___________________

____

Past Medical History: Have you ever been told you have any of the following?

Cancer	Yes	No	Ulcers	Yes	No
Heart problems	Yes	No	Infectious diseases	Yes	No
High Blood Pressure	Yes	No	Lung problems	Yes	No
Angina/Chest Pain	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	Anemia	Yes	No
Diabetes	Yes	No	Allergies	Yes	No
Osteoporosis	Yes	No	Fibromyalgia	Yes	No
Thyroid problems	Yes	No	Kidney disease	Yes	No
Rheumatoid arthritis	Yes	No	Stroke	Yes	No
Osteoarthritis	Yes	No	Seizures/Epilepsy	Yes	No
Depression	Yes	No	Other	____________________	

Currently, are you experiencing any of the following? (circle all that apply):

Fever/chills/sweats	Poor balance (falls)	Unexplained weight loss	
Numbness/tingling	Changes in appetite	Difficulty swallowing	Pelvic pain
Depression	Shortness of breath	Changes in bowel or bladder function	
Dizziness	Nausea/vomiting	Night Pain	Headaches

How have you been sleeping at night? Fine Disturbed only with medication
During the past month, have you been bothered by feeling down, depressed or hopeless? Y / N
During the past month, have you had little interest or pleasure in doing things? Y / N

Current History:
What date (approximately) did your present symptoms start? ___________________________________

How? (gradually, suddenly, injury) ____

How have your symptoms changed? getting better about the same getting worse

What makes your symptoms better? ____

What makes your symptoms worse? ____

Have you had an x-ray, MRI, or other testing for this problem? No / Yes (specify) ____________________

What treatments have you received for this problem so far? _____________________________________

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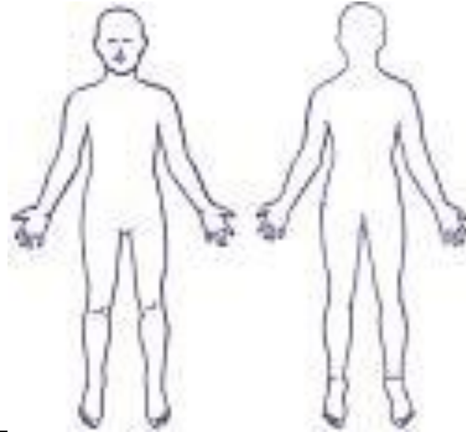
Body Chart:
Mark the areas where
you feel your symptoms.



On the scale below, circle the number which best represents the average level of pain you have experienced over the last 48 hours:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

Circle the number below which best represents your overall average level of function:

0	1	2	3	4	5	6	7	8	9	10
Cannot do anything										Able to do everything

Aggravating Factors: Identify up to 3 important activities that you are unable to do or have difficulty with as a result of your problem.

1) ____
2) ____
3) ____

During the past 3 months, have you seen any medical professional (doctor, chiropractor, PT, osteopath, etc)? Yes / No If yes, please describe the reason. ___________________________

____

List any other injuries you have had that required medical attention. ________________________

____

What are your personal goals for therapy at this time? ____

____

CONSENT: My diagnosis and treatment plan will be discussed during my appointment and I understand that I have the right to question and/or refuse any treatment offered. The information I have provided above is accurate and complete.

_____________________________________ (signature)

________________________ (date)

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