**Patient Name:** ______________________ *Medical History Intake Form*

**Date of Birth:** ____/____/____ **Age:** ____ **Today's Date**____/____/____

**Referred By:**

**Where do you have pain or a problem (which body part)?**

**Does the pain travel or radiate?** Yes No | **Where does it radiate to?**

**How long have you had this problem?** ____ weeks months years **Onset on pain?** gradual sudden

**What makes it *worse*?** sitting standing walking lying down Other:

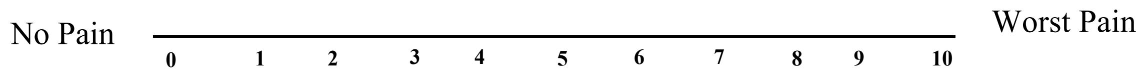
**Please describe what the pain feels like:** achy sharp stabbing numbness tingling cramping stiff

**What diagnostic tests have you had done for this problem?** X-ray MRI CT Ortho Consult EMG

**What treatments have you had?** none meds injections physical therapy psychotherapy chiropractic

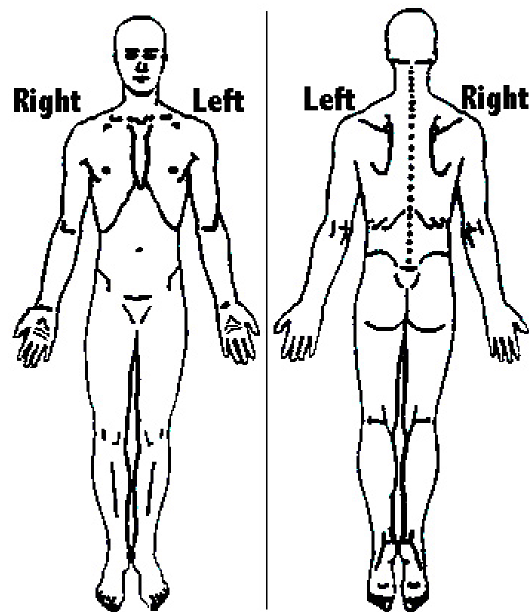
**Please indicate the level of discomfort you have today.**

No Pain Worst Pain




***Medications*:**
**(Current)**

**Please draw where you have Pain**




***Medical/Surgical History:***
*ie* Surgeries, Diabetes, Cancer,
High blood pressure, Heart attack,
Pacemaker, Arthritis, Fractures,
Accidents, Osteoporosis

***Allergies* to medicines:**

***Family History:***
Cancer, Heart disease, Stroke,
Arthritis, Osteoporosis

***Social History:* Occupation:**

**Tobacco use** (cigarette, cigar, pipe, chew): current past never

*Review of Systems*

| | | |
|---|---|---|
| **Unexplained weight loss?** | Yes | No |
| **Vision change?** | Yes | No |
| **Headaches?** | Yes | No |
| **Chest pain?** | Yes | No |
| **Shortness of breath?** | Yes | No |
| **Loss of control of stools?** | Yes | No |
| **Loss of control of urine?** | Yes | No |
| **New rashes?** | Yes | No |
| **Weakness?** | Yes | No |
| **Depressed mood?** | Yes | No |
| **Sleep problems?** | Yes | No |
| **Anxiety?** | Yes | No |
| **Joint swelling?** | Yes | No |