Health History

This is a confidential record of your medical history. Information contained here will not be released to any person except when you have authorized such a release in writing.

Today's Date: _____ Name: _____
Sex: M F Age: _____ Date of Birth: _____
Marital Status: _____ Occupation: _____

Please list your major complaints in order of importance or state reason:

_____
_____
_____

Concerning your most important complaint:
Describe your symptoms (include frequency, duration, severity and character) and if you have any pain or numbness, fill out the diagram on following page:

_____
_____
_____

When did the condition first begin? _____

_____

If known state cause: _____

_____

What makes your condition better of worse? _____

_____

Is this problem getting better, worse, or remaining the same? _____
What methods have you tried to alleviate this problem? _____

_____

Have you consulted other healthcare professionals for this problem? If so give names and dates: _____

_____

If you were disabled from work because of this problem, please give dates:

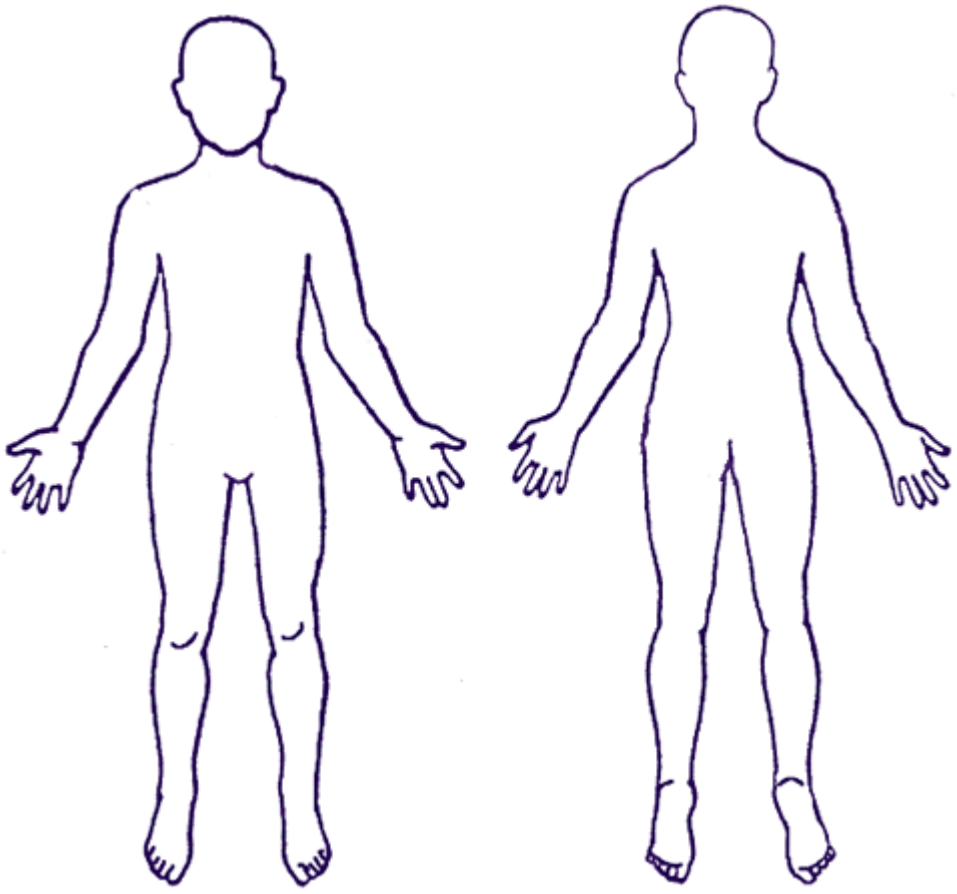
_____

Pain & Numbness Patterns

Please draw your areas of pain and/or numbness in the human diagrams below using the following key:

Pain: Light shading as moderate pain **Numbness: Use XXX to indicate numbness**

Dark shading as severe pain



(Front) **(Back)**

0 ← 5 **→ 10**

Pain Scale: Please place X at your subjective rate of pain.

0 = No Pain
10 = Severe Pain

Print Form