

PATIENT HEALTH HISTORY

Name: _____ Age: _____ Date: _____

Sex: Male Female Marital Status: Single Married Divorced Widowed # Children: _____

Chief Complaint - List Current Problems:

1. _____ Duration (How Long) _____
2. _____ Duration (How Long) _____
3. _____ Duration (How Long) _____

Please mark the intensity of your pain today

1- NO PAIN
10 - MOST INTENSE EVER FELT

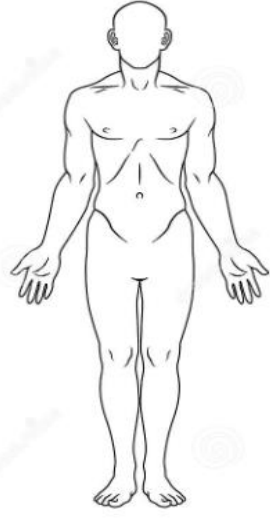
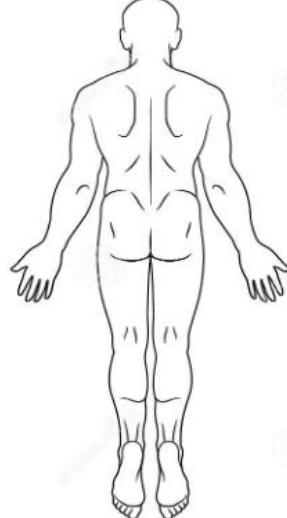
Example

	Neck									
	1	2	3	4	5	6	7	8	9	10
1.	1	2	3	4	5	6	7	8	9	10
2.	1	2	3	4	5	6	7	8	9	10
3.	1	2	3	4	5	6	7	8	9	10

DOCTOR'S USE ONLY

Please mark area & type of pain on the drawings using the code listed below

N -Numbness	P- Pain	T- Tingling
A- Ache	S - Soreness	ST - Stiffness

HABITS

Smoking Packs/Day _____

Drinking Alcohol/Day _____

Coffee Cups/Day _____

EXERCISE

None

Moderate

Daily

Type: _____

FAMILY HISTORY

	Diabetes	Heart	Cancer	Back
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother, No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister, No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Measles	<input type="checkbox"/> Goiter	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Mumps	<input type="checkbox"/> Influenza	<input type="checkbox"/> Mental Disorder
<input type="checkbox"/> Polio	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Lumbago
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Eczema
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Cancer	<input type="checkbox"/> Venereal Infection	<input type="checkbox"/> HIV Positive

OPERATIONS AND PROCEDURES

DATE	DATE	DATE
_____ Vaccinations	_____ Tubes In Ears	_____ Sinus
_____ Tonsillectomy	_____ Appendectomy	_____ Hernia
_____ Gall Bladder	_____ Female Organs	_____ Thyroid
_____ Back Operation	_____ Rectal Surgery	_____ Stomach
_____ Other:	_____ Other:	_____ Other: