NEW PATIENT HISTORY/HEALTH SURVEY

Full Name _____ Age _____ Date _____

Describe your complaint and how it happened? _____

_____

_____

1. **The date this episode began?** _____
2. **Was this episode caused by:** ❑ Work Injury ❑ Car Accident ❑ Other trauma ❑ Unknown
3. **Since the onset (of this episode) have you been?** ❑ Worse ❑ Better ❑ No Change
4. **Do you notice your complaint:** ❑ Intermittently ❑ Constantly (100% of the day – No Relief)
5. **Work Status: How many jobs do you have?** _____ ❑ Full-time ❑ Part-time
   ❑ Homemaker ❑ Student ❑ Retired ❑ Disabled ❑ Unemployed
6. **Due to your complaint are you off work or not performing your regular home chores?** ❑ **N** ❑ **Y**
   Complete: _____Days off work _____Days unable to perform household tasks
   Partial: _____Days of job modification _____Days of decreased household tasks
7. **Are you currently under a medical doctor's care?** ❑ **N** ❑ **Y** *Explain?* _____
8. **List all surgeries or medical issues:** _____
9. **List all Medications:** _____
10. **Do You Have A Pacemaker Or Any Surgically Implanted Device?** ❑ **N** ❑ **Y**
    Explain: _____
11. **Women: Are You Now or Could You Be Pregnant?** ❑ **N** ❑ **Y**
12. **Circle the Number to any Question you answer as YES.**
    1. Do you have recurring headaches? **2**. Are you losing weight without trying? **3.** Do you wake up at night with pain? **4.** Have you had a change in bowel or bladder habits? **5.** Do you have a sore that doesn't heal? **6.** Have you recently had any unusual bleeding or discharge? **7.** Do you have a thickening/lump in the breast or elsewhere? **8.** Do you have indigestion or difficulty swallowing? **9.** Have you had an obvious change in a wart or mole? **10.** Do you have a nagging cough or hoarseness? **11.** None of # 12's questions pertain to me.
13. **Circle below or add any past or present diagnoses:**
    Herniated Disc, Bulging Disc, Osteoporosis, Rheumatoid Arthritis, High Blood Pressure, Cancer, Stroke Diabetes, ***Other:*** _____
15. **Circle anything that pertains to you:** Taking Blood Thinners, Spinal Surgery, Carotid Artery Surgery, Present Smoker, Past Smoker, Taking Birth Control (Women Only), **DENY ALL**
16. **Circle anything below that you may have experienced within the past 2 weeks:**
    Nausea, Vomiting, Fever, Diarrhea, Vertigo, Difficulty Walking, Loss of Consciousness, Double Vision, Blurred vision, Ringing in Ears, Speech Problems, Memory Loss, Head Injury, Clumsiness, Trauma, **DENY ALL**