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Initial Health Status Form

Today's Date: _____/_____/________

Name: ____ Birth Date: _____-______-_____ Age: __________

Sex: M / F / Other Preferred language: Marital Status: Single / Married / Divorced / Widowed

Address: ____City: _______________ State: _______ Zip: _____________

Home Phone: _____________________ Cell Phone: ______________________ Work Phone: _____________________

E-mail Address: ____________________________________ Is it ok to send appointment reminder text messages? Yes / No

Preferred Method of Contact: Email/ Home Phone /Cell Phone Do you have Insurance: Yes / No

Employer: __________________________________ Occupation: ____

Emergency Contact: _______________________ Phone Number: ___________________ Relationship: ____________

How were you referred to this office? ____

HISTORY OF COMPLAINT

What is the reason for your visit? Please **identify** and **number** based on the severity of the condition(s) that brought you to this office:

____

When did the problem(s) begin? ____

How did the problem(s) begin? ____

Is your problem the result of ANY type of injury/accident? Yes No If Yes: Auto Home Other ____________

If yes, please explain: ____

Current complaint level (*how do you feel today)* on a scale of 0 to 10, with 0 being no pain and 10 being Unbearable.

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Constant / Intermittent

Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Constant / Intermittent

Average pain intensity: last 24 hours: No pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: No pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

How often do you experience your symptoms?

Intermittently (0 – 25% of times) Occasionally (26 – 50% of times) Frequently (51 – 75%) Constantly (76% - 100%)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on activities.

Patient name: Date:

In general, would you say your overall health right now is: Excellent Very Good Good Fair Poor

When is the problem at its worst? AM PM mid-day late PM

Have you suffered from the same or similar condition before? No Yes

If yes, how many times? _____________ When was the last episode? ____

Have you tried other treatments? No Yes If yes, please state what type of treatment:

____

How long ago? ____ Were the results: Favorable Unfavorable

Have you tried anything to make it feel better (e.g., medication, ice, heat etc.)? ___________________________________

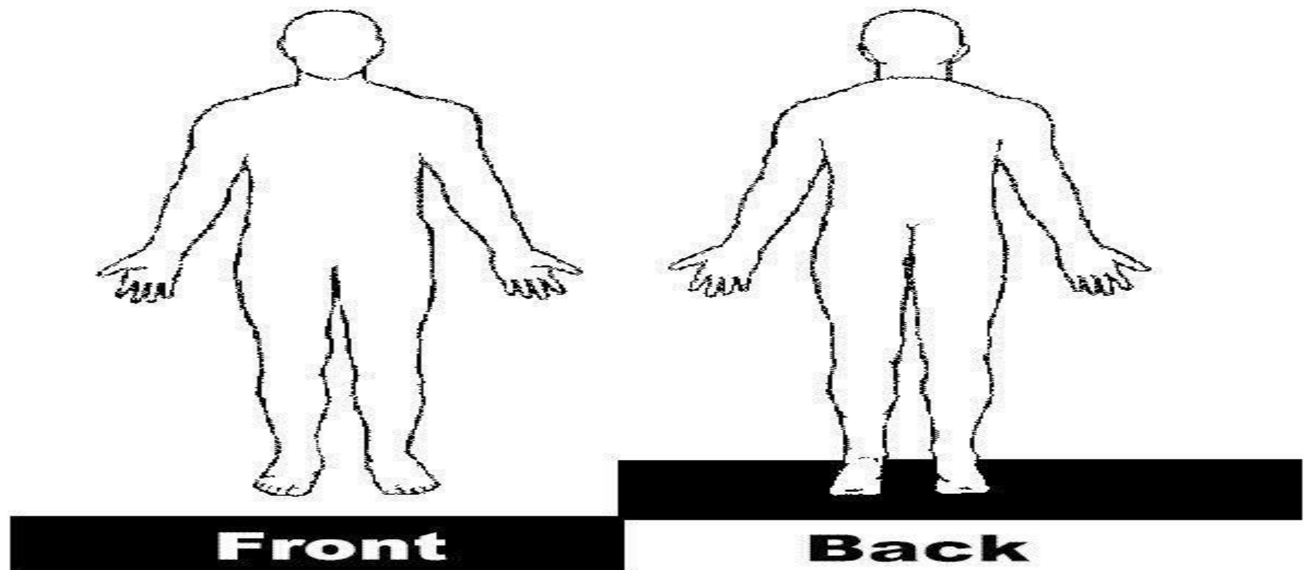
Have you tried anything to make it feel worse (e.g., lying down, walking, sitting etc.)? ______________________________

HAVE YOU HAD SPINAL X RAYS, MRI, OR CT SCAN FOR YOUR AREA(S) OF COMPLAINT? No Yes

Date(s) Taken _____________________________ What areas were taken? __________________________________

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling



Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

____

PAST HISTORY

If you have ever been diagnosed with any of the following conditions, please indicate with a C for Currently or P for the Past

_____ Alcohol/Drug Dependence

_____ Recent Fever

_____ Diabetes

_____ High blood pressure

_____ Stroke (Date) ____________

_____ Numbness in Groin/Buttocks

_____ Corticosteroid Use (Cortisone, Prednisone, etc.)

______ Dizziness/Fainting

Patient name: Date:

_____ Taking birth control pills
_____ Numb/Tingling arms, hands, fingers
_____ Numb/Tingling legs, feet, toe
_____ Urinary Problems
_____ Visual Disturbances/Blurred or Double Vision
_____ Hip Pain
_____ Shoulder Pain
_____ Neck Pain
_____ Upper Back Pain
_____ Low Back Pain
_____ Mid Back Pain
_____ Broken Bone
_____ Sleeping Problem
_____ Menstrual Problems
_____ Menopausal problems
_____ Constipation
_____ Prostate Problems
_____ Abnormal Weight Gain or Loss
_______ Loss of Balance
_____ Digestive Problems
_____ Osteo Arthritis
_____ Scoliosis/Back Curvature
_____ Low Blood Pressure
_____ Allergies

_____ Cancer/Tumor
_____ Rheumatoid Arthritis
_______ Epilepsy/Seizures
_____ Currently Pregnant (# ____ weeks)
_____ Vertigo
_____ Jaw Pain/TMJ
_____ Ringing in the ears
_____ Chest Pain
_____ Impotence/Sexual Dysfunction
_____ Heartburn
_____Pain w/Cough/Sneeze
_____ Depression/Mood Changes
_____ Swollen/Painful Joints
_____ Hepatitis (A, B, C)
_____ Dislocations
_____Gall Bladder Trouble
_____ Osteoporosis
_____ Learning Disability
_____ Frequent Colds/Flu
_____ Heart Attack/Problem
_____ Asthma
_____ Kidney Trouble
_____ Tremors
_____ Disability

Other Serious Conditions: ____

SOCIAL HISTORY:

1. Smoking: Cigars Pipe Cigarette How often? Daily Weekends Occasionally Never
2. Alcoholic Beverage: How many glass/bottles? ____ Daily Weekends Occasionally Never
3. Recreational Drug use: Yes No Never Daily Weekends Occasionally Never
4. Hobbies -Recreational Activities- Exercise Regime**:** How does your present problem affect? (See ADL form)

____

5. Sleep pattern: ____ How many hours per night? ____________________

Patient name: Date:

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	TYPE OF CARE RECEIVED TYPE OF CARE RECEIVED BY WHOM
INJURIES	1. 2. 3.
SURGERIES	1. 2. 3.
CHILDHOOD DISEASES	1. 2. 3.
ADULT DISEASES	1. 2. 3.

FAMILY HISTORY:

____ Cancer ____ Diabetes ____High Blood Pressure ____ Heart problem/Stroke ___ Rheumatoid Arthritis

Whom: grandmother grandfather mother father sister(s) brother(s) son(s) daughter(s)

Any other hereditary conditions the doctor should be aware of? No Yes

____

List Prescription and Non-Prescription drugs you take:
____

____

ACTIVITIES OF LIFE:

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Write a number where applies: 1 – Painful (can do) 2 – Painful (limits) 3 – Unable to Perform

Extended computer use Climbing upstairs Static sitting Sleep Sit to Stand

Sweeping/Vacuuming Climbing downstairs Yard Work Dishes Lifting Children/Groceries

Read/Concentrate Sexual Activities Walking Shaving Washing/Bathing

Getting Dressed Laundry Garbage Driving Static standing

Other: ____

____ _____ - _____ - _____

Patient or Authorized Person's Signature Date Completed

____ _____ - _____ - _____

Doctor's Signature Date Form Reviewed