

Do not write, stamp, punch holes or affix a sticker in this area. To reproduce, follow the printing instructions.

Personal / Family History

Please answer every question

Handwritten items must be entered MANUALLY.

Do not fold this form.

Marking Instructions

Please use a #2 pencil. Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Name and birth date input fields

When did this problem first start?

Was this due to an accident? If yes, what was the accident date:

Is there a legal case pending? yes no

Is there a worker's compensation case? yes no

TOBACCO USE

What is your smoking status? current (every day) current (some days) previous never

At what age did you begin smoking?

EXAMPLE: If you started smoking at the age of 21, you would fill in the ovals like this: 10 20 30 40 50 60 70 80 90 1 2 3 4 5 6 7 8 9

If you quit smoking, at what age did you quit?

How many cigarettes do you currently smoke (or did you previously smoke) per day?

How many cigars or pipes do you smoke per week?

How many cans of smokeless / chewing tobacco do you use per week?

Are you exposed to secondhand smoke? yes no

ALCOHOL USE

Number of times: never 1 2 3 4 5 6 7+ Per: week month year

(If you marked "never", please skip ahead to DRUG USE section)

What type(s) of alcohol do you drink? beer wine liquor

How many drinks do you have per occasion? 1-2 3-5 6-9 10+

How often do you have more than five drinks per occasion? never rarely occasionally frequently

DRUG USE

none current previous prefer to discuss with physician

HIV HIGH RISK BEHAVIOR?

(HIV Risk Factors: IV drug use, more than one sexual partner, sex with a prostitute, unprotected sexual contact, contact with contaminated injection equipment.) yes no prefer to discuss with physician

HABITS

Caffeine Type(s) of caffeine: coffee tea soft drinks Drinks per day: occasionally 0 1-2 3-5 6-9 10+

Exercise

Type(s) of exercise: bicycling walking running aerobics swimming other Times per week: occasionally 0 1-2 3-4 5-6 7+

Do not write, stamp, punch holes or affix a sticker in this area. To reproduce, follow the printing instructions.

Personal / Family History

Please answer every question

Handwritten items must be entered **MANUALLY**. Do not fold this form.

You are: right-handed left-handed

What is your occupation? _____

Are you currently working? yes no

How many children do you have? NONE 1 2 3 4 5 6 7 8 9 10+

TREATMENTS

What treatments have you tried for your problem:

- Bracing
- Heat / Ultrasound
- Physical Therapy
- Traction
- Chiropractic Manipulation
- Massage
- Spine Exercises
- Other** (please specify): _____
- Epidural Steroid Injections
- Medications
- TENS Unit

CHILDHOOD ILLNESSES

What childhood illnesses have you had:

- Chicken Pox
- Measles
- Rheumatic Fever
- Other** (please specify): _____
- Rubella
- Mumps
- Scarlet Fever

PAST MEDICAL HISTORY

Please indicate if **YOU** have a history of the following:

- AIDS / HIV
- Heart Murmur
- Pacemaker
- Anemia
- Hemophilia
- Peptic Ulcer
- Cancer (type): _____
- Hemorrhoids
- Phlebitis
- (location): _____
- Hepatitis
- Prostate Cancer
- Diabetes
- Hernia
- Rheumatoid Arthritis
- Emphysema
- High Blood Pressure
- Sinusitis
- GERD
- High Cholesterol
- Skin Cancer
- Glaucoma
- Kidney Stones
- Thyroid Disease
- Heart Attack
- Liver Disease
- Other** (please specify): _____
- Heart Disease
- Osteoarthritis
- Osteoporosis
- NONE**

FAMILY MEDICAL HISTORY

Family History UNKNOWN

NO SIGNIFICANT FAMILY MEDICAL HISTORY

Please indicate which family members have had these illnesses:

	Father	Mother	Brother	Sister	Son	Daughter
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Attack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lung Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Multiple Sclerosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spine Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tuberculosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OTHER (please specify): _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SURGERIES

Please list your surgical procedures, your age at the time of the surgery and your surgeon's name:

Procedure: _____ Procedure: _____ Procedure: _____

Age: _____ Age: _____ Age: _____

Surgeon's Name: _____ Surgeon's Name: _____ Surgeon's Name: _____