PATIENT HISTORY

What issue brings you here today? ____

How/When did it start? ____

What makes it worse? _______________________ Better? _______________________

Any tests done (X-ray, MRI, etc.)? ____

Therapies tried: Massage Physical Therapy Chiropractic Acupuncture Other: ____________

Rate your pain 0-10 at worst: __________ At best: __________ Now: __________

Describe your pain (circle): dull achy sharp tingling cramping tight burning

Is pain (circle): improving worsening staying the same

Stress level (0-10): ________ Difficulty sleeping? Y N

Do you work outside the home? If so, what do you do? ______________________________

Are you able to currently work? Y N Activities/Hobbies affected? __________________

Primary emotional state: anxious depressed angry/irritable grief worried calm

Do you experience:

Headaches?	Y	N	Dizziness?	Y	N
Chest pain/palpitations?	Y	N	Urinary problems?	Y	N
Pelvic pain?	Y	N	Anxiety?	Y	N
Breathing problems?	Y	N	Depression?	Y	N

What medications are you taking? ____

____

Past Medical History/surgeries: ____

____

History of physical traumas (accidents, falls, injuries)? Explain: _______________________

____

Recent Emotional trauma? emotional violence sexual violence loss/grief other: __________

____

Childhood/past traumas: physical violence emotional violence sexual violence

parental addiction neglect abandonment other: ____________________