**Patient Health History**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please explain current condition/injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pain levels (0 best, 10 worst)**

**Current\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ At Best\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ At Worst\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are symptoms getting better, worse, or no changes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What aggravates your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What gives relief to your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What are your treatment goals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had any of the following (If yes, please circle)?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Fever, chills** | **Blurred vision, Dizziness** | **Unexplained weight change**  | **Night sweats (unrelated to menopause)**  | **Fatigue**  |
| **Night pain (unrelieved by change in position)**  | **Blood in urine/stool** | **Depression** | **Unexplained muscle weakness**  | **Suicidal thoughts**  |
| **Falls** | **Fainting** | **Numbness/tingling** | **Hallucinations**  | **Anxiety**  |

**Do you have a pacemaker? Yes No**

**Do you have any implanted devices (pump, IUD, Stimulators) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you pregnant or planning to be pregnant? Yes No**

**Please list any medications, supplements, herbs:**

**Please list past surgical history:**

**Have you ever had any of the following conditions? Y = current, N = never, P = significant issue in the past**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Cancer** | **Y N P** | **Heart Disease**  | **Y N P** | **Ankle Swelling**  | **Y N P** |
| **High or Low Blood Pressure** | **Y N P** | **Low Back Pain** | **Y N P** | **Sacroiliac Pain** | **Y N P** |
| **Tailbone Pain** | **Y N P** | **Alcohol Abuse**  | **Y N P** | **Drug Abuse**  | **Y N P** |
| **Depression** | **Y N P** | **Disordered Eating** | **Y N P** | **Smoking**  | **Y N P** |
| **Vision Issues**  | **Y N P** | **Hearing Issues**  | **Y N P** | **Swollen Glands**  | **Y N P** |
| **Anemia**  | **Y N P** | **Anal Fissures**  | **Y N P** | **Stroke**  | **Y N P** |
| **Epilepsy**  | **Y N P** | **Multiple Sclerosis**  | **Y N P** | **Head injury** | **Y N P** |
| **Osteoporosis**  | **Y N P** | **Chronic fatigue syndrome** | **Y N P** | **Fibromyalgia**  | **Y N P** |
| **Arthritic Conditions** | **Y N P** | **UTI’s** | **Y N P** | **Joint Replacements**  | **Y N P** |
| **Stress Fractures**  | **Y N P** | **TMJ pain** | **Y N P** | **Neck Pain** | **Y N P** |
| **Post Traumatic Stress Disorder** | **Y N P** | **Blood Clots**  | **Y N P** | **Anal Fistula** | **Y N P** |
| **Emphysema or Bronchitis**  | **Y N P** | **Asthma**  | **Y N P** | **Allergies**  | **Y N P** |
| **Latex Sensitivities**  | **Y N P** | **Thyroid Issues**  | **Y N P** | **Headaches** | **Y N P** |
| **Diabetes**  | **Y N P** | **Kidney Issues**  | **Y N P** | **IBS** | **Y N P** |
| **Crohn’s Disease**  | **Y N P** | **Diverticulitis**  | **Y N P** | **Sexually Transmitted Disease**  | **Y N P** |
| **Physical Abuse**  | **Y N P** | **Sexual Abuse**  | **Y N P** | **Pelvic Pain**  | **Y N P** |
| **Hemorrhoids**  | **Y N P** | **Bladder Infections**  | **Y N P** |  |  |