Health History Form

Please complete this form with as much detail as possible. The information you provide is *strictly confidential*. While many of the questions may seem unrelated to your main complaint, all of the information is extremely helpful in order to make an accurate diagnosis and provide you with the best possible care and results. Thank you for your time.

Name:_____Date_____

Address:_____Zip_____

DOB:_____Email:_____

Phone to reach you:_____Referred by:_____

Physician Name:_____Occupation:_____

Emergency Contact & Phone_____

Main complaint_____

-How severe is the **intensity** on a scale of 0-10: (Best=0 Worst= 10):
When symptom is at its best: /10 When symptom is at its worst: /10

-If there is pain involved, what is the quality of pain? (Circle all that apply):
Dull, Achy Burning Sharp/Stabbing Cold Numb/Tingling Traveling Throbbing

-What makes the pain/symptom feel **better**? (Circle all that apply):
Heat Cold Damp Weather Wind Rest Work Movement Sitting Touch/Pressure Steroids Stress Meds

-What makes the pain/symptom feel **worse**? (Circle all that apply)
Heat Cold Damp Weather Wind Rest Work Movement Sitting Lying Touch/Pressure Steroids Stress Meds

Significant Trauma (physical or emotional)

_____

Surgeries

_____

Allergies

_____

Medications

_____

_____

_____

Vitamins/Supplements

_____