**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** |  |  |