



Confidential Patient Health Record

Today's Date: ____ / ____ / ____

How did you hear about us?

- Family
Doctor
Drove by
Close to home / work

- Friend / Coworker
Radio / Media
Insurance Plan
Other

Personal Information

Last name, First name, Middle Initial, DOB, Age, Sex, Social Security #, Address, Apt #, City, State, Zip, Home Phone, Work Phone, Cell Phone, Fax Number, Email Address, Spouses Name

Emergency Contact

Last name, First name, Address, Apt #, City, State, Zip, Home Phone, Cell Phone, Email Address, Relationship

Employer Information

Business Name, Address, Suite #, City, State, Zip, Work #, Fax #

Current Medication(s) List any and all medications you are currently taking. Be Specific

Medication	Dosage	For What Condition	Time On Medication

Current Vitamins, Herbs or Supplements. (Be Specific)

Product	Dosage	For What Condition	Time On Medication

Surgery (ies) List all Surgical Procedures. Write the date of the procedure below

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Cosmetic | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> Joint Reconstr | <input type="checkbox"/> Rotator Cuff |
| <input type="checkbox"/> Caesarian Section | <input type="checkbox"/> Dental Surgery | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Spinal Fusion |
| <input type="checkbox"/> Cardiac Cath | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Knee Repair | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Laminectomy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Coronary Bypass | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Other |

Chief Complaint – HPI (History of Present Illness)

Patient Name: _____ Case: _____ Date: _____

Chief Complaint: _____

Please Tell Us More About Your Chief Complaint. Is Your Chief Complaint in your:

Neck Low Back Mid Back Arm / Hands Leg / Feet

What other complaints are you having? _____

Is this condition: New (or) Chronic

Did this begin with:

Auto Accident: Driver Passenger Pedestrian Leg / Feet

Work Related: Fall Falling Object Overexertion Lifting

Repetitive Motion Other _____

Other – Liability: Slip / Fall Don't Know Overuse Other

Does it feel like: Pain Numbness Stiffness Weakness

Location: Left / Right _____

Quality:

Burning Diffuse Dull /Aching Localized Radiating

Sharp Shooting Stabbing Throbbing Tightness

Tingling Other Left Right Both Sides

Level of Pain when Resting (Scale 0 thru 10) 0=no pain – 10=unbearable _____

Level of Pain with Activity (Scale 0 thru10) 0=no pain – 10=unbearable _____

When did this begin? _____

Has this happened before? _____

Is it worse in the morning / afternoon / evening? _____

With activity is it constant or intermittent? _____

Better or worse with warm, cold, or damp conditions? _____

Other: _____

Radiation: Left / Right? _____

Weakness: Left / Right? _____

Headaches:

Location: Frontal Temporal Base of Skull Sinus

Quality: Dull Sharp Throbbing Stabbing

Aura No Aura

Types: Hat Band Cluster Migraine Tension

Other Associated Signs and Symptoms:

Aches Burning Cold limb(s) Difficulty Walk Dizziness

Fatigue Heartburn Joint Stiffness Vomiting Fever

Nausea Muscle spasm Muscle weakness Numb/tingling Panic

Pins/needles Pale Bluish Skin Shortness Breath Swelling Sweating

Modifying Factors: (Symptoms Better With)

Activity Bending Nothing helps Apply cold Apply heat

Massage Movement OTC meds RX meds Rest

Stretching Sitting Standing Twisting Walking

Symptoms Worse With: (as noted in Social History)

Since condition began, has anything permanently helped you? No (or) Yes

Has anything that you have done, thus far fixed your problem? No (or) Yes

Employment:

Occupation/Job Title: _____ Work: _____ Hrs/day or week

Description / Work: _____

Job Classification: Sedentary (5lbs) Light (5-20lbs) Moderate (20-50lb) Heavy(>50lbs)

Lifting Frequency:: Constant (67-100%/day) Frequent (33-66%/day) Occasional (1-32%/day)

Lifting Posture: With Arms High Near From Knee Off Posture From Torso

Work Activity Posture: (hours per day)

Bending: _____ Climbing: _____ Kneeling: _____ Pulling: _____ Pushing: _____

Sitting: _____ Reaching: _____ Standing: _____ Twisting: _____ Walking: _____

Repetitive Activities: (hours per day)

Assembly/fine manipulation: _____ Computer use/typing: _____ Grasping: _____

Hand tool use:: _____ Machinery controls: _____ Phone use: _____

Daily Activities: How does the symptoms effect your ability to perform your job?

No Effect

Mild (Painful, but can do)

Moderate (Painful, limited)

Severe (Unable to Perform)

	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Bending:	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Care – Infirm Family:	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Carrying Groceries:	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Change Position:	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Climb Stairs:	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Driving:	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Extended Computer Use:	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Eating	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Household Chores:	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Kneeling:	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Lifting Child:	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Lifting	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Pet Care:	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Reading (concentration):	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Self Care:	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Sexual Activities::	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Sleep::	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Static Sitting:	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Static Standing:	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Walking:	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
Yard Work:	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe
	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe