

HEALTH HISTORY

What is your major complaint or symptom? _____

How long have you had this condition? _____

Have you been treated for this condition before? Y or N If yes, when? _____

Who were you treated by for this condition? _____

Other complaints _____

How important is it to you to eliminate your symptoms?

CIRCLE: Not Important... 0 1 2 3 4 5 6 7 8 9 10 ...Very Important

Have you ever had an AUTO accident? Y or N If yes, when? _____

Were you treated for injuries? Y or N If yes, where? _____

Have you ever had a personal injury? Y or N If yes, when? _____

Have you ever filed a Workers' Comp claim? _____ **CIRCLE:** Open Closed

Primary Care Physician _____ Phone _____

Date of last Physical Exam _____ Are you or could you be pregnant? Y or N

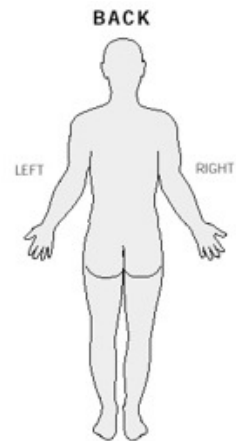
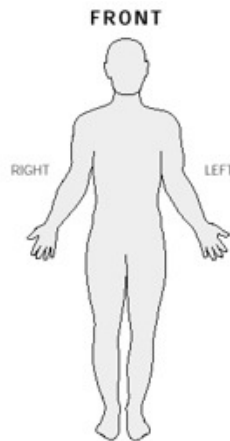
Are you currently taking any medications? Y or N If yes, please list _____

Please mark your areas of pain on the figures.

///// Sharp

xxx Burning

+++ Ache



Are you now or have you suffered from any of the following:

Headaches	Yes	No	Difficulty Sleeping	Yes	No
Loss of Taste	Yes	No	Anxiety	Yes	No
Loss of Smell	Yes	No	Depression	Yes	No
Asthma	Yes	No	Urinary Disorders	Yes	No
Allergies	Yes	No	Bedwetting	Yes	No
Dizziness	Yes	No	Ear Disorders	Yes	No
Nausea/Vomiting	Yes	No	Sinus Trouble	Yes	No
Heart Disease	Yes	No	Constipation/Diarrhea	Yes	No
Heart Attack	Yes	No	Menstrual Disorders	Yes	No
Stroke	Yes	No	Sexual Dysfunction	Yes	No
Previous Surgeries	Yes	No	Chronic Fatigue	Yes	No
Digestive Disorder	Yes	No	Chronic Tension	Yes	No

If you answered yes, please describe and list date(s) _____

Please list previous surgeries and the date(s) _____

Does anyone else in your family have this or a similar problem? Y or N If yes, please describe:

Who?	What problem?	Care they are receiving
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

I certify that I have answered the above information to the best of my knowledge.

Patient Signature _____ **Date** _____