Health History Form

Do you have any close family history (father/mother, grandparents, aunts/uncles) of any of the following:

❒ Thyroid problems ❒ Diabetes ❒ Gout ❒ Heart conditions ❒ Kidney problems ❒ Ovarian/uterine problems
❒ Liver problems ❒ Gallbladder problems ❒ Stomach problems ❒ Colon problems ❒ Lung conditions ❒ Strokes

Have you had the flu, a cold, or a respiratory illness (cough) in the last 3 weeks? ❒ Yes ❒ No

Do you smoke? ❒ Yes ❒ No When was your last smoke?: _____

Have you experienced a recent trauma (a fall, sports injury, car accident, dental work, surgery, etc.)? ❒ Yes ❒ No
Are you now or have you ever been disabled? ❒ Yes ❒ No When: _____ How:_____

Please answer the following questions in regard to the chief complaints you described on pages 1 and 3.

COMPLAINT

1:	**2:**	**3:**
When and how did this problem begin?		
❒ suddenly ❒ gradually	❒ suddenly ❒ gradually	❒ suddenly ❒ gradually
What makes it better ? / What makes it worse ?		
How would you describe your pain/symptoms ?		
❒ achy ❒ sharp ❒ burning	❒ achy ❒ sharp ❒ burning	❒ achy ❒ sharp ❒ burning
❒ sore ❒ tight & stiff	❒ sore ❒ tight & stiff	❒ sore ❒ tight & stiff
❒ numb ❒ pins & needles	❒ numb ❒ pins & needles	❒ numb ❒ pins & needles
How often do you experience your pain/symptoms ?		
❒ constantly (100%) ❒ frequently (75%)	❒ constantly ❒ frequently	❒ constantly ❒ frequently
❒ intermittently (50%) ❒ occasionally (25%)	❒ intermittently ❒ occasionally	❒ intermittently ❒ occasionally
Does the pain radiate anywhere ?		
❒ down the arms ❒ legs	❒ down the arms ❒ legs	❒ down the arms ❒ legs
Is your complaint affected by the time of day ?		
❒ worse in the morning ❒ evening	❒ worse in morning ❒ evening	❒ worse in morning ❒ evening
❒ better in the morning ❒ evening	❒ better in morning ❒ evening	❒ better in morning ❒ evening
Are you getting: (Circle) worse / better / same	worse / better / same	worse / better / same