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PATIENT HISTORY FORM

PATIENT NAME _____ DOB _____ TODAY'S DATE _____

1. BACKGROUND

Birthplace _____
Marital Status _____
Age of spouse/significant other ____ Deceased/Age ____
Highest level of education completed _____
Your occupation _____
Hours worked per week _____
Referred here by _____
Name of person making the referral _____
Primary Care Physician _____
Do you have an orthopedic surgeon? ☐ YES ☐ NO
If yes, the surgeon's name _____

2. PRESENT SYMPTOMS

Briefly describe your current symptoms:

Date that symptoms began (approx.) _____
If your problem was diagnosed previously, what was the diagnosis? _____
Previous treatment for this problem (excluding meds)
☐ Physical therapy ☐ Surgery ☐ Injections
☐ Other: _____
List names of other practitioners you have seen for this problem: _____

3. RHEUMATIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following?

	YOU	RELATIVE(S)		YOU	RELATIVE(S)
Arthritis (unknown type)	☐		Lupus or "SLE"	☐	
Osteoarthritis	☐		Gout	☐	
Rheumatoid arthritis	☐		Ankylosing Spondylitis	☐	
Childhood arthritis	☐		Osteoporosis	☐	

4. SOCIAL HISTORY

YES NO

☐ ☐ Do you drink caffeinated beverages?
If so, how many cups per day?
☐ ☐ Do you currently smoke? If you smoked in the past, when did you start: stop:
☐ ☐ Do you drink alcohol?
If yes, how many drinks per week?
☐ ☐ Has anyone told you to cut down on drinking?
☐ ☐ Do you use drugs for non-medical reasons?
If yes, what types? _____
If yes, how many times per week?
☐ ☐ Do you get enough sleep?
How many hours of sleep do you get?
☐ ☐ Do you wake up feeling rested?

5. PAST MEDICAL HISTORY

Please list any significant illnesses you have had.

PROBLEM	COMMENTS

List natural or alternative therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

6. PREVIOUS OPERATIONS, FRACTURES & INJURIES

Enter types of operations you have had:

Year	Type of Operation	Reason

Enter types of fractures you have had:

Year	Type of Fracture	Reason

List any serious injuries you have had: _____

Number of pregnancies: _____

7. FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

	Number	Number Living	Deceased	Cause(s)
Siblings				
Children				

Health of your children: _____

List any blood relatives (father, mother, etc.) who have had the following ailments:

Cancer		Type:	
Leukemia		Epilepsy	
Stroke		Asthma	
Tuberculosis		Psoriasis	
Bleeding Tendency		Diabetes	
Heart Disease		Colitis	
Hypertension		Alcoholism	
Rheumatic Fever		Goiter	