

PATIENT HISTORY

Date of Birth _____ Social Security Number _____ - _____ - _____
Last Name _____ First Name _____
Address _____ Apt # _____
City _____ St _____ Zip _____
Phone (H) _____ (W) _____ (C) _____
Spouse's Name _____
Your Occupation _____ Employer _____
Employer Address _____
Insurance Company _____ Policy Number _____
Have you ever been to another doctor for this problem? ___ Y ___ N Who? _____
Who referred you to this office? _____

WHAT BRINGS YOU TO OUR OFFICE?

FIRST COMPLAINT: _____

- Date when symptom first appeared _____
- Did it begin ___ Gradual ___ Sudden ___ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain ___ Sharp ___ Dull ___ Ache ___ Burn ___ Throb
- Does the Pain Radiate into your ___ Arm ___ Leg ___ Does not radiate
- Do you experience Numbness or Tingling? ___ Y ___ N
- How often do you experience these symptoms?
___ 100% ___ 75% ___ 50% ___ 25% ___ 10%
- PAIN INTENSITY: Please put line on the scale describing the intensity of your pain.

No Pain | 0 _____ | 5 _____ | 10 | Unbearable Pain

OTHER COMPLAINT: _____

- Date when symptom first appeared _____
- Did it begin ___ Gradual ___ Sudden ___ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain ___ Sharp ___ Dull ___ Ache ___ Burn ___ Throb
- Does the Pain Radiate into your ___ Arm ___ Leg ___ Does not radiate
- Do you experience Numbness or Tingling? ___ Y ___ N
- How often do you experience these symptoms?
___ 100% ___ 75% ___ 50% ___ 25% ___ 10%
- PAIN INTENSITY: Please put line on the scale describing the intensity of your pain.

No Pain | 0 _____ | 5 _____ | 10 | Unbearable Pain

PATIENT SIGNATURE _____ DATE _____