HISTORY FORM

Patient Name: _____ Date: _____

Please answer these questions to the best of your ability. This will help your doctor understand your pain better.

List the three areas that are causing you the most pain: _____

SYMPTOMS

***** Check any symptoms that you have:**

☐ Neck Pain	☐ Headaches	☐ Arm Pain (R/L)	☐ Chest Pain
☐ Mid Back Pain	☐ Dizziness	☐ Leg Pain (R/L)	☐ Rib Pain
☐ Low Back Pain	☐ Blurred Vision Pain	☐ Hand Pain (R/L)	☐ Abdominal Pain
☐ Tailbone Pain	☐ Pain Behind Eyes	☐ Foot Pain (R/L)	☐ Jaw Pain
☐ Pelvic Pain	☐ Nausea	☐ Wrist Pain (R/L)	☐ Clicking/Popping Jaw
☐ Tingling/ numbness in leg/foot (R/L)	☐ Vomiting	☐ Ankle Pain (R/L)	☐ Tooth Pain
☐ Tingling/ numbness in arm/hand (R/L)	☐ Memory Loss	☐ Shoulder Pain (R/L)	☐ Ringing/buzzing in the ears
☐ Radiating Neck Pain into_____	☐ Trouble Sleeping	☐ Knee Pain (R/L)	☐ Fatigue
☐ Radiating Back Pain into_____	☐ Loss of Balance	☐ Hip Pain (R/L)	☐ Anxiety

☐ Other: _____

BRUISING/BURNS/CUTS: *Check all areas where you still have bruising, cuts, or burns.*

☐ Hand (R/L)	☐ Foot (R/L)	☐ Ribs	☐ Hip	☐ Seat Belt Burn: _____
☐ Arm (R/L)	☐ Ankle (R/L)	☐ Chest	☐ Face	☐ Broken Teeth:
☐ Shoulder (R/L)	☐ Leg (R/L)	☐ Breast	☐ Back	☐ Air Back Burn/Scrapes: _____

☐ Other: _____

FAMILY HISTORY

Is there a family history of:

☐ Diabetes ☐ Stroke ☐ Heart Disease ☐ Cancer ☐ High Blood Pressure ☐ Other: _____

Have you ever had back problems before? ☐ YES ☐ NO If YES, explain: _____

Have you ever been in a car accident before? ☐ YES ☐ NO If YES, when: _____

Did you have any residual complaints from any previous accidents BEFORE you were in this accident? ☐ YES ☐ NO

If YES, explain:

PAST SURGERIES

Please list all past surgeries

Operation	Date	Operation	Date

DRUG ALLERGIES

☐ NONE

_____

_____

_____

_____

CURRENT MEDICATIONS

_____

_____

_____

_____

Remember to list any medication prescribed to you at the hospital.

Dr. Signature Confirming Review with Patient: _____