

Patient History

Name: _____ date: _____

Insurance #: _____ (dd/mm/yr)

DOB: _____ M / F

Review intake questionnaire

Presenting complaint

1. Location/radiation
2. Onset (when/how)
3. Chronology/timing/prior episodes
4. Quality (sharp, dull, shooting)
5. Severity (0-10)/effect on ADL
6. Modifying factors (better/worse)
7. Associated symptoms (NTW)
8. Treatment history/relevant prior injuries/X-rays
9. Why seeking care now
10. Treatment goals

Past health history

1. Serious illness
2. Hospitalizations/surgeries (including residual problems)
3. General trauma, accidents, injuries (including residual problems)
4. Menses, menopause
5. Contraceptives, pregnancies
6. Medications: prescription/OTC (purpose, dose, frequency)
7. Allergies
8. X-rays/imaging
9. Prior care (chiro, naturo, medical, massage, PT)
10. Last physical (date/results)

Family health history

1. Hereditary disease/family health problems

Personal/social history

1. Living situation
2. Occupation (activities/hours)
3. Exercise (activities/frequency)
4. Interests / other activities
5. Diet (good, fair, poor)
6. Sleep pattern (wake rested)
7. Bowel habits (freq., changes)
8. Urinary habits (changes, prob.)
9. Habits (alcohol, tobacco, drugs)
10. Stress factors

"Is there anything else?"

Signature: _____

Date: _____