HISTORY AND PHYSICAL

PATIENT NAME: _____ PHONE:_____

EMERGENCY CONTACT NAME/PHONE: _____

YOUR OCCUPATION: _____

WERE YOU REFERRED BY SOMEONE? IF SO, WHO_____

ANY ACCIDENTS (AUTO/ATV/MOTORCYCLE/BOATING/ FARMING/ SPORTS/WORK / ETC:

_____

DOB: _____ AGE: ___ SEX:_____RACE:_____HEIGHT:_____WEIGHT:_____

SMOKE: YES NO ALCOHOL: YES NO

DISEASES: (HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, DIABETES, THYROID, ETC):

_____

PAST SURGICAL HISTORY:_____

CIRCLE WHAT AREAS YOU HAVE PAIN:

NECK PAIN MID BACK PAIN LOW BACK PAIN LEG PAIN- R/L

KNEE PAIN-R/L FOOT PAIN-R/L SHOULDER PAIN-R/L HEADACHES

OTHER _____

WHEN DID YOU PAIN BEGIN? _____

WHEN DOES THE PAIN OCCUR THE MOST? _____

FAMILY DOCTOR: _____ SPECIALIST _____

HAVE YOU HAD ANY RECENT XRAYS, CT SCANS OR MRI'S? _____

DO YOU HAVE ANY CHILDREN? YES / NO

IF SO WHAT ARE THEIR AGES AND GENDERS? _____ _____ _____

IS YOUR MOTHER STILL LIVING? YES/NO. IF NO WHAT WAS THE CAUSE OF DEATH?_____

IS YOUR FATHER STILL LIVING? YES/NO. IF NO WHAT WAS THE CAUSE OF DEATH?_____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

DO YOU HAVE ANY HOBBIES OR SPECIAL INTEREST? _____

DO YOU HAVE AN EMAIL ADDRESS? _____