



ADULT PATIENT HISTORY

Name: _____ Date: _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: _____ Height: _____

Are you latex sensitive: YES ____ No ____ Do you smoke? Yes ____ No ____

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the follow (check all that apply)?

- | | | |
|--|---|--|
| <input type="checkbox"/> Changes in your health | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Falls |
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pain at night |
| <input type="checkbox"/> Dizziness/lightheadedness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fever/chills/sweats | <input type="checkbox"/> Difficulty maintaining balance while walking | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Changes in bowel or bladder function | |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Diarrhea | |

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- | | | |
|---|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Other arthritic condition | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Depression | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Chest pain/angina |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Sexually transmitted disease/HIV |
| <input type="checkbox"/> Pacemaker inserted | <input type="checkbox"/> Other _____ | <input type="checkbox"/> High cholesterol/lipids |
| <input type="checkbox"/> Chemical dependency (i.e., alcoholism) | | |

During the past month have you been feeling down, depressed or hopeless? YES ____ NO ____

During the past month have you experienced little interest or pleasure in doing things? YES ____ NO ____

Is this something with which you would like help? YES ____ YES, BUT NOT TODAY ____ NO ____

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES ____ NO ____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES ____ NO ____

Please list current medications: _____

Are you now or have you ever taken blood thinning or anticoagulants: YES ____ NO ____

Please list any surgeries or other conditions for which you have been hospitalized:

1. _____ 2. _____ 3. _____

What date (roughly) did your present symptom(s) start? _____

What do you think caused your symptom(s)? _____

My symptoms are currently: Getting Better ____ Getting Worse ____ Staying about the same ____

Treatment received so far for this problem (chiropractic, injections, etc) _____

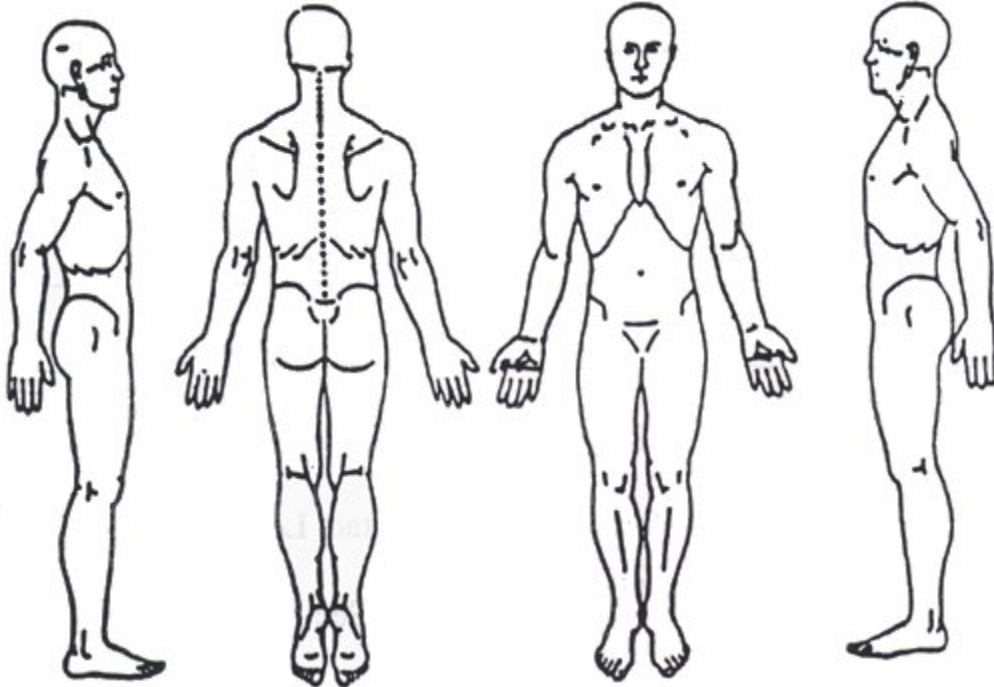
Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: ____ Yes ____ No When _____ Treatment received _____

How long did it take for you to feel better? _____

*****PLEASE COMPLETE THE BACK OF THIS FORM*****

Please mark the areas where you feel your symptoms with the following symbols:



III Numbness = Tingling ↓ Shooting/sharp pain O Dull/ache pain

My symptoms currently: Come and go _____ Are Constant _____ Are constant, but change with activity _____

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

- _____
- _____
- _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

- _____
- _____
- _____

How are you sleeping at night?

Difficulty getting to sleep _____ Awakened by pain _____ Sleep only with medication _____ Sleep through the night well _____

When are your symptoms worst? Morning _____ Afternoon _____ Evening _____ Night _____ After exercise _____

When are your symptoms the best? Morning _____ Afternoon _____ Evening _____ Night _____ After exercise _____

On the scale below, please circle the number which best represents your levels of pain:

Average: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Best for past 48 hours: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Worse for past 48 hours: No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

What is your goal for therapy at this time? _____

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