DR. GUY'S PATIENT HISTORY FORM

Patient Name: _____ Date of Birth: _____

So that we may better understand your unique condition,
please complete the following information with regard to your current complaint.

Location:

What Is The Purpose Of Your Treatment? _____

What Is Your Primary Complaint? _____

What Caused The Onset? _____ When Did It Start? _____

Does The Complaint Radiate Or Travel? If So, Where: _____

Timing and Duration:

- ✓ Since the onset of your complaint, how has it been changing? ☐ Getting Better ☐ Not Changing ☐ Getting Worse
- ✓ How often do you experience this complaint? ☐ Constantly (100%) ☐ Frequently (75%) ☐ Occasionally (50%) ☐ Intermittently (25%)
- ✓ Does your complaint worsen? If so, When: ☐ Morning ☐ Midday ☐ Night ☐ Sleep ☐ Work ☐ Other: _____
- ✓ How much has the complaint interfered with your normal work (including both work outside the home and housework)?
  ☐ Not At All ☐ A Little Bit ☐ Moderately ☐ Quite A Bit ☐ Extremely
- ✓ How much would you say this complaint has affected your social activities?
  ☐ All Of the Time ☐ Most Of the Time ☐ Some Of the Time ☐ A Little Of the Time ☐ None Of the Time

Severity:

Use the key below to rate the severity of your pain:

0 = No Pain	1 = Minimal	2 = Very Mild	3 = Mild	4 = Mild to Moderate	5 = Moderate	6 = Moderate to severe
7 = Mildly Severe	8 = Severe	9 = Very Severe	10 = Excruciating			

Please circle where you rate your pain: 1 2 3 4 5 6 7 8 9 10

Quality:

- ✓ How would you describe the sensation of your complaint?
  ☐ Sharp Pain ☐ Shooting ☐ Numbness ☐ Tingling
  ☐ Dull Ache ☐ Burning ☐ Throbbing ☐ Other: _____

Modifying Factors:

- ✓ What makes your complaint feel worse? (please list)

_____

Alleviating Factors:

- ✓ What makes your complaint feel better? (please list)

_____

Previous Treatment:

Who have you seen for this condition? ☐ Medical Doctor ☐ Physical Therapist ☐ Chiropractor ☐ Other: _____

Have you had Chiropractic care in the past? ☐ Yes ☐ No If so, When? ____/____/_____

Risk Factors:

Do you have a pacemaker? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No ☐ Maybe/Uncertain

Do you have metal implants, devices, or prosthetics? ☐ Yes ☐ No

History was obtained from: ☐ Patient ☐ Parent ☐ Guardian ☐ Child ☐ Other: _____

PAST & GENERAL HISTORY

In an effort to provide you with the best care possible, please take a moment to answer the following questions related to your past history, medication history, and injury & surgical history.

Past History: (please list any other past health issues or conditions)

Musculoskeletal Issues: _____

Neurological Issues: _____

Head, Eyes, Nose, Throat Issues: _____

Cardiovascular Issues: _____

Respiratory Issues: _____

Bladder or Bowel Issues: _____

Skin Issues: _____

Autoimmune Conditions: _____

Medication History: (please list any medications you are currently taking)

_____

_____

What Other Supplements or Vitamins Are You Taking?

_____

_____

Injury and Surgical History:

What, If Any, Major Injuries Have You Had? When?

_____

_____

Have You Been Hospitalized Or Had Surgery? If So, When and Why?

_____

_____

FAMILY & SOCIAL HISTORY

In an effort to provide you with the best care possible, please take a moment to answer the following questions related to your family history, social history, and daily activities.

Family History Information:

Please list any conditions or health issues anyone in your family currently has, or has had in the past below:

_____

_____

_____

_____

Social History:

Please describe your social history below:

Do you use alcohol, caffeine, illicit drugs, or tobacco products? _____

Do you exercise, how often? _____

Do you sleep well, how many hours a night? _____

Describe your diet? _____

Describe your job? _____

Daily Activities:

So that we may have an idea as to your daily routine, please list a few of your daily activities and your favorite hobbies:

_____

_____

Does Your Current Condition Affect Your Performance In These Activities Or Hobbies?

☐ Yes ☐ No If Yes, How? _____

Primary Care Physician: _____ PCP Phone: _____

Last Seen: ____/____/____ **May We Update Them On Your Condition? ☐ Yes ☐ No**

Patient / Guardian Signature: _____ Date: ____/____/____

Dr: _____