PATIENT HISTORY FORM

NAME:____________________________________ DATE:________________
DATE OF BIRTH/AGE:_________________________

Name of the physician who referred you to see a neurosurgeon:
____
City and State of referring physician: _______________________________
Is your referring physician a chiropractor? Yes No
Name of your family physician: _____________________________________
Have you seen a physical therapist this year? Yes No
Have you previously been treated for this particular problem? Yes No
Did your physician send medical records? Yes No

HPI

Where is the pain located? ____

When did the problem start? ____

On a scale of 1 to 10, 10 being the worst, how severe is the pain? _______

Is there any particular time of day or activity when the pain is worse?
____

What have you found to help alleviate the pain?
____

Please circle or list any other symptoms.

Difficulty walking	Nausea
Facial weakness or numbness	Constipation
Ringing in your ears	Lack of appetite
Loss of coordination	Difficulty sleeping
Hearing loss	Nightmares
Vertigo	Tiredness
Dizziness	Urinary Problems
Weakness	Headaches
Vomiting	Feeling Drowsy
Diarrhea	Sweating

Please circle any of the following which describe the pain.

aching	throbbing	shooting
stabbing	gnawing	pricking
sharp	tender	burning
cramping	squeezing	penetrating
numb	radiating	dull

Did this problem arise from an injury or accident? Yes No

If yes, please explain.____

____

Did this injury occur at work? Yes No

Have you had this problem before? Yes No

If so, when? ____

What type of work do you do? ____

Have you missed work due to the problem? Yes No

If so, when? ____

When was the last day you were able to work? ______________________________

Have you had any test for this problem? Yes No

PAST MEDICAL HISTORY

Please circle any condition you have been diagnosed with:

High Blood Pressure	Diabetes	Ulcers	Fibromyalgia
Chest Pain	Blood Clot in Leg	Stroke	Arthritis
Heart Trouble	Asthma	Epilepsy	Heart Attack
Abnormal Heart Rhythm	Liver Disease	Emphysema	Skin Disorders
Psychological Disorder	Osteoporosis	Loss of Vision	

Please list any other illnesses: ____

____

____

PAST SURGICAL HISTORY

Please list all surgeries you have had and the date of surgery.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

List all medications you are taking, including medicines not requiring a prescription.

Medication	Dosage (mg)	No. of tablets	Times per day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

ALLERGIES

Medications you are allergic to: ____

Other allergies: ____

Latex allergies? Yes No

If you are taking any herbal medicines circle below or list: ________________________

Echinacea
Ephedra
Garlic
Ginkgo
Kava
St. John's Wort
Valerian
Ginseng
Gingko biloba
Vite
Valerian Root

FAMILY HISTORY

Is your father living? Yes No If yes, age:____ If no, deceased at age: _____

Is your mother living? Yes No If yes, age:____ If no, deceased at age: _____

Have any family members been diagnosed with the following;

	Father	Mother	Children	Brother/Sister	Grandparent
Diabetes	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Heart trouble	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
High blood Pressure	☐	☐	☐	☐	☐

SOCIAL HISTORY

Marital Status: Single Married Widowed

Number of Children: _______________ Do you live alone? Yes No

Do you smoke? Yes No If so, packs per day? ________ No. of years? _____
If you formerly smoked, how long has it been since you quit? _________________
If you use tobacco of other forms, please list. ______________________________

Do you drink? Yes No If so, how much?________________________________

If you smoke or drink, and find you need surgery, would you be willing to quit for one week prior to surgery and six weeks after surgery to decrease the chances of complications? Yes No

What is your occupation? ___________________ Hours a week at work? ________

Do you exercise routinely? Yes No If so, how often? ________________

Please circle the appropriate test below and list the date and location.

Name of test	Date	Location
MRI	____________	______________________________
CAT SCAN	____________	______________________________
ANGIOGRAM	____________	______________________________
SPINAL XRAYS	____________	______________________________
SKULL FILMS	____________	______________________________
EMG	____________	______________________________
NCV	____________	______________________________
TRIAL STIMULATOR	____________	______________________________
OTHERS: ______________	____________	______________________________

If surgery is required, would you be receptive to blood product? Yes No

Signature:____

DO NOT WRITE BELOW THIS LINE.

Vital signs: **B/P ________________________** **Pulse___________________**
Temp ______________________ **Weight ________________**