PATIENT HISTORY AND PHYSICAL QUESTIONNAIRE

Patient Name:	DOB:	Gender: Male Female
Hand Dominant: Right Or Left	Height:	Weight:

Please describe current medical problem including date of onset and correlate with pain chart using the symbols below:

Description:

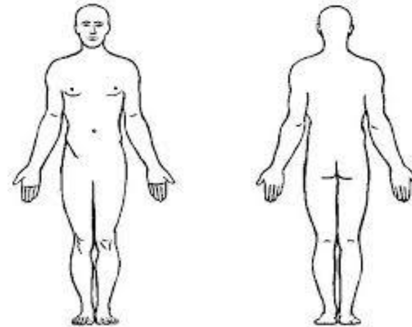
Ache: ^^

Burning: xx

Numbness: //

Pins and Needles: 00

Stabbing: ll



List any previous Surgeries you have had:

Date	Type	Surgeon	Hospital

Do you take Aspirin or Aspirin-containing products? Yes No Unsure	Do you smoke? Yes No	Do you drink? Yes No	Have you had a drug addiction? Yes No

List you prescribed drugs and over-the-counter drugs, such as pain medication and muscle relaxants:

Drug Name	Strength	Frequency

List any allergies to food or medication and type of reaction:

Please circle if any member of your immediate family had a history of:

Asthma Cancer Diabetes Gout Heart Disease High Blood Pressure Lung Disease Rheumatoid Arthritis Ulcers

Check if you have, or have had, any of the following conditions:

Arthritis	Headache	Pacemaker: Insertion Date:
Asthma	Heart Attack	Stroke
Blood Pressure	Hepatitis Type:	Thyroid Disease
Chest pain / Angina	Hernia	Ulcer
Diabetes	Kidney Problems	Other:

I have read and understand the above questionnaire and certify that the answers giver are correct to the best of my knowledge. I authorize the release of my medical records for the purpose of treatment and for reasons deemed necessary as provided by HIPPA.

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(Printed Name) (Signature) (Date)

I am not pregnant at this time and have no intentions of becoming pregnant while under the care of any physician in the practice. I understand that during my course of treatment I may receive medication, x-rays, and/or medical intervention that could cause fetal damage. I release the above physician from any and all responsibility for fetal damage.

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(Printed Name) (Signature) (Date)