ToccoChiropractic
&Rehabilitation

PATIENT HISTORY FORM

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name: _____ Date: _____

Occupation: _____ Age: _____

1. What problem are you being seen for today?

   Primary Complaint _____

   Secondary Complaint _____

2. When (approximate date) did your pain/problem begin? _____

3. How did your pain start?

❑ Suddenly	❑ Gradually	❑ Lifting
❑ Twisting	❑ Falling	❑ Bending
❑ Pulling	❑ Injured at work	❑ Auto Accident
❑ Hit in back	❑ Sports	❑ No apparent cause

4. When does the pain worsen?

❑ During exercise	❑ Walking	❑ Coughing
❑ After exercise	❑ Bending	❑ Sneezing
❑ Sitting	❑ Bending forward	❑ Other _____

5. Which of the following reduces your pain?

❑ Lying down	❑ Manipulation	❑ Listening to music
❑ Sitting	❑ Pain pills	❑ Nothing
❑ Standing	❑ Muscle relaxers	❑ Other _____
❑ Walking	❑ Aspirin	

6. Are there any activities you cannot do because of your pain? ❑ No ❑ Yes

   If yes, please list: _____

7. Has your discomfort caused you to miss work? ❑ No ❑ Yes

8. Have you seen other doctors for this condition? ❑ No ❑ Yes

   If yes, please list: _____

9. Please list all medications you are currently taking (including over-the-counter medication):

10. Amount of alcohol consumed per day? ❑ Light ❑ Moderate ❑ Heavy ❑ None

11. Amount of coffee/tea consumed per day? _____cups per day

12. Do you take antacids? ❑ No ❑ Yes

13. Tobacco use? ❑ No ❑ Yes

14. Have you had any of the following diagnostic studies done?

MRI	❑ No	❑ Yes	Where _____	Date _____
X-Rays	❑ No	❑ Yes	Where _____	Date _____
CAT Scan	❑ No	❑ Yes	Where _____	Date _____
Myelogram	❑ No	❑ Yes	Where _____	Date _____
EMG Studies	❑ No	❑ Yes	Where _____	Date _____
Discogram	❑ No	❑ Yes	Where _____	Date _____
Bone Scan	❑ No	❑ Yes	Where _____	Date _____

Patient History & Review of Systems Questionnaire

Patient Name: _____ Date: _____

Have you ever been in an auto accident ❑ Yes ❑ No Date: _____

Have you ever filed a workman's Comp Claim? ❑ Yes ❑ No Date: _____

Injured area: _____

Have you ever had and EKG (electrocardiogram) ❑ Yes ❑ No _____

Do you participate in any sports/excercise? ❑ Yes ❑ No _____

Do you use illicit drugs? ❑ Yes ❑ No _____

Personal History Illnesses: Have you ever had the following:
(Please circle all "YES" answers)

Measles ..... Y
Mumps ..... Y
Whooping Cough ..... Y
Diphtheria ..... Y
Pneumonia ..... Y
Pleurisy ..... Y
Arthritis/Rheumatism ..... Y
Rheumatic Fever/Heart Disease ..... Y
Polio/Meningitis ..... Y
Gonorrhea/Syphilis/STD ..... Y
Anemia ..... Y
Bladder Disease ..... Y
Migraine Headaches ..... Y
Diabetes ..... Y
Hives/Eczema ..... Y
Hemorrhoids/Rectal Disease ..... Y
Food/ Chemical/Drug Poisoning ..... Y
High/Low Blood Pressure ..... Y
Any Other Disease ..... Y
_____ Y

German Measles ..... Y
Chicken Pox ..... Y
Scarlet Fever/Scarlatina ..... Y
Smallpox ..... Y
Influenza ..... Y
Neuritis ..... Y
Any Bone/Joint Disease ..... Y
Bursitis/Sciatica/Lumbago ..... Y
Nephritis ..... Y
Gallbladder Disease ..... Y
Jaundice ..... Y
Epilepsy ..... y
Tuberculosis ..... Y
Cancer ..... Y
Colitis/Bowel Disease ..... Y
Nervous Breakdown ..... Y
Hay Fever/Asthma ..... Y
Frequent Infections/Boils ..... Y

ALLERGIES:
Penicillin/Sulfa ..... Y
Aspirin/Codeine/Morphine ..... Y
Mycins/ Other Antibiotics ..... Y
Any other drug ..... Y
Any foods ..... Y
Adhesive tape ..... Y
Nail Polish/Cosmetics ..... Y
Tetanus Antitoxin/Serums ..... Y
Metal ..... Y
INJURIES:
Broken/Cracked Bones ..... Y
Sprains ..... Y
Lacerations ..... Y
Dislocations ..... Y
Concussion/Head Injury ..... Y
Knocked Unconscious ..... Y

Surgery

Tonsillectomy ❑ Yes ❑ No Appendectomy ❑ Yes ❑ No
Any other operations ❑ Yes ❑ No

Details: _____

_____

Have you been advised to have any surgical operation that has not been done? ❑ Yes ❑ No

Details: _____

_____

_____

Have you been hospitalized for any illness? ❑ Yes ❑ No

Details: _____

_____

_____

Pregnancies # of births_____ # Vaginal_____ # C-section_____
Any possibility of pregnancy at this time? ❑ Yes ❑ No