CONFIDENTIAL PATIENT HISTORY

Date:_____

Name:_____ Soc Sec#:_____

Address:_____City:_____State:_____Zip:_____

Birth Date:_____ Age:_____ Marital Status (circle one): M S D W

Cell #_____ Home#_____ Work#_____

Occupation:_____ Email Address: _____

Primary Doctor: _____ Referred by:_____

PATIENT HISTORY:

Where do you have pain? _____

Does anyone in your immediate family suffer from this same or similar problem? _____

How long have you been suffering with this? _____

How did it occur?_____

Any pain or numbness in the arms or legs?_____

How often/frequent do you get the pain?_____

What makes it better?_____

What makes it worse?_____

On a scale of 1 to 10, how severe is the pain (1=very mild, 10=very severe)? _____

Have you seen any other doctors for this condition?_____

What have you done to try to alleviate this problem? _____

Have you become discouraged/worried about getting rid of it? _____

When it's at its worst, how much older does it make you feel? _____

On a scale of 1 to 10, rate your commitment to getting rid of this problem… _____

Does your pain interfere with work, or any hobbies/interests? _____