PRECISION
Pain Relief Center

Patient Health History

Today's Date [/ /] **Signature of Patient** ______________________

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name______________________ **Nick Name**______________________

Last Name ______________________ **Middle Name** ______________**Suffix** ________

Address 1 ______________________

Address 2 ______________________

City______________________ **State**__________ **Zip Code** ______________

Home Phone ______________________**Work Phone** ______________________

Mobile Phone ______________________

Home email ______________________ **Work Email** ______________________

Would you like to receive our Email Newsletter? ❑ Yes ❑ No

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Home Phone ❑ Work Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth [/ /] **Age** _______ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** ______________________

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check all that apply)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other_________ ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Continued …

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Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the Chosen question: ______________________________

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Current medications, including dosage if known.
If there are no current medications, check here: ❑

1) ______________________ **5)** ______________________

2) ______________________ **6)** ______________________

3) ______________________ **7)** ______________________

4) ______________________ **8)** ______________________

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) ______________________ **3)** ______________________

2) ______________________ **4)** ______________________

Briefly list your main health problems: ______________________________

____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: ______________

____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ______________________________

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: ______inches **Weight:** __________ pounds **BP:** _______ / ________

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What brings you to our office? (Please provide as much detail as possible)

PRIMARY COMPLAINT: ____________________

Date of first symptoms: ____________________ Did it begin: ❑ Gradually ❑ Suddenly ❑ Progressive over time

What makes the symptoms increase? ____________________ What relieves the symptoms? ____________________

Type of pain: ❑ Sharp ❑ Dull ❑ Ache ❑ Burn ❑ Throb Does the pain radiate into your: ❑ Arm ❑ Leg ❑ Does not radiate

Do you have numbness or tingling? ❑ Yes ❑ No How often do you feel these symptoms? ❑ 100% ❑ 75% ❑ 50% ❑ 25% ❑ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 = no symptoms, 10 = extreme): ____________________

Please list all previous treatments for this condition (give doctor's name and dates, if possible): ____________________

____

Do you have any family members who suffer from the same complaint? If so, who? ____________________

SECONDARY COMPLAINT: ____________________

Date of first symptoms: ____________________ Did it begin: ❑ Gradually ❑ Suddenly ❑ Progressive over time

What makes the symptoms increase? ____________________ What relieves the symptoms? ____________________

Type of pain: ❑ Sharp ❑ Dull ❑ Ache ❑ Burn ❑ Throb Does the pain radiate into your: ❑ Arm ❑ Leg ❑ Does not radiate

Do you have numbness or tingling? ❑ Yes ❑ No How often do you feel these symptoms? ❑ 100% ❑ 75% ❑ 50% ❑ 25% ❑ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 = no symptoms, 10 = extreme): ____________________

Please list all previous treatments for this condition (give doctor's name and dates, if possible): ____________________

____

Do you have any family members who suffer from the same complaint? If so, who? ____________________

____________________ Patient Printed Name

____________________ Patient Signature

____________________ Date

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Please list any of the following: (include dates where possible):

Surgeries: ______________________________

Hospitalizations: ______________________________

Accidents (car, work or home): ______________________________

Traumas (falls, broken bones, etc.) ______________________________

Serious Illness: ______________________________

Please check if you have had any of the following:

☐ AIDS/HIV	☐ Alcoholism	☐ Anemia	☐ Allergy Shots	☐ Difficulty Sleeping
☐ Anorexia	☐ Arthritis	☐ Asthma	☐ Bleeding Disorders	☐ Breast Lump
☐ Bronchitis	☐ Bulimia	☐ Cancer	☐ Cataracts	☐ Chemical Dependency
☐ Chicken Pox	☐ Diabetes	☐ Disc Degeneration	☐ Emphysema	☐ Epilepsy
☐ Epilepsy	☐ Glaucoma	☐ Goiter	☐ Gonorrhea	☐ Gout
☐ Heart Attack	☐ Heart Disease	☐ Hepatitis	☐ Hernia	☐ Herpes
☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Liver Disease	☐ Measles
☐ Migraine	☐ Miscarriage	☐ Mononucleosis	☐ Multiple Sclerosis	☐ Mumps
☐ Osteoporosis	☐ Pacemaker	☐ Parkinson's Disease	☐ Pinched Nerve	☐ Pneumonia
☐ Polio	☐ Prostate Problem	☐ Prosthesis	☐ Psychiatric Care	☐ Stroke
☐ Rheumatic Fever	☐ Scarlet Fever	☐ Suicide Attempt	☐ Thyroid Problems	☐ Tonsillitis
☐ Tuberculosis	☐ Tumors/Growths	☐ Typhoid Fever	☐ Ulcers	☐ Vascular Disease
☐ Vaginal Infections	☐ Venereal Disease	☐ Whooping Cough	☐ Rheumatoid Arthritis	

☐ Other: ______________________________

Patient Printed Name	Patient Signature	Date

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