Physicians Health and Rehab PC
21995 Highway 32, Sainte Genevieve, MO 63670
Phone (573) 883-2442
Fax (573) 883-2281

Patient Health History

Reason for seeking care:____

Date of injury:___________________________ Date of symptoms:______________________________

Have you had same or similar condition before? Y N If yes, when:______________________________

List any other doctors seen for this: ____

List any diagnosis and type of treatment: ____

Have you had similar accidents or injuries before? __ Yes __ No If yes, explain: _____________________

List the names of any relatives that have or have had a similar problem: ____________________________

Have you or any relative received chiropractic treatment previously? __ Yes __ No

If yes, explain: ____

Have you been treated for any health condition by a physician in the last year? __ Yes __ No

If yes, explain: ____

Are you currently taking medication? __ Yes __ No list medications: _____________________________
____

Have you taken medication in the past? __ Yes __ No list medications ______________________________

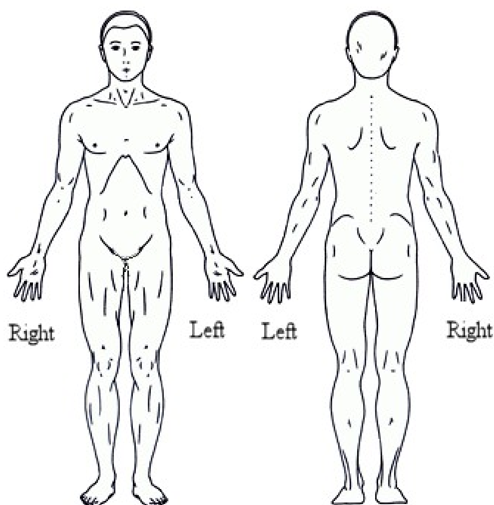
List conditions you are taking medications for: ____

List the approximate dates of any surgery or treated conditions:____

Family History: Health conditions, age of death and cause of death.
Father: ____
Mother: ____
Brother/s & Sister/s: ____

Do you smoke Y/N ____ Alcohol Y/N __Daily __Weekly __Social Occasions Caffeinated drinks per day ____

Do you take Vitamins/Supplements Y/N If yes, type and how often _____________________________________



Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10 Using the symbols below, mark on the pictures where you feel pain.

Numbness = = =
Dull Ache OOO
Burning XXX
Sharp/Stabbing / / /
Pins, Needles + + +
Other ______ ^ ^ ^

What activities aggravate your condition/pain?___________
What activities lessen your condition/pain?______________ Is this condition worse during certain times of the day? Y/N Is this condition interfering with Work?__________ Sleep?__________Routine?_______Other?___________

Is this condition progressively getting worse?____

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Please mark each item below for each sign or symptom you presently have or previously had.

(Mark P for Past and C for Current):

GENERAL SYMPTOMS

__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS

__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR

__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT

__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL

__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY

__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY

__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES

__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy ______________

FOR WOMEN ONLY

__ Birth Control _________
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain

Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient Signature____Date__________________________