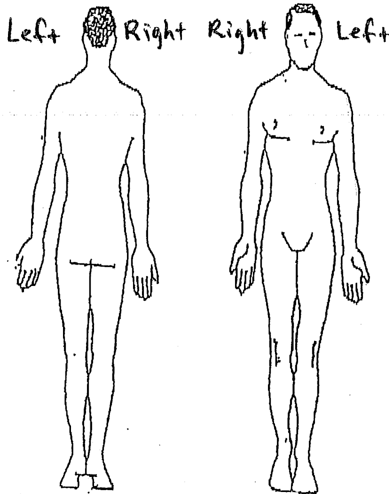
PATIENT HISTORY (PVT)

Name:______________________ Height:______ Weight:______ Left or Right Handed: L / R
Referred By: __________________________

1. Mark the areas on your body where you feel pain or numbness/tingling:



When did symptoms first start? __________________________

Are the symptoms getting: ☐ Worse ☐ Better ☐ No Change

Body parts affected: __________________________________
____

Type of pain: ☐Sharp ☐Aching ☐Throbbing ☐Burning

Pain radiation (Describe): ______________________________
____

Pain rating (circle): **0** - 1 - 2 - 3 - 4 - **5** - 6 - 7 - 8 - 9 - **10**
No Pain | Moderate Pain | Severe pain

2. Do you have any other symptoms (numbness, dizziness, urinary incontinence, etc.)?
____

3. Do you have any weakness in your arms or legs? ______________________________
____

4. Please describe any injury in detail: ______________________________________
____
____
____
____

5. Have you had these complaints evaluated or treated by another physician? If so, please list their names and treatments provided. ☐ Dr. _________________ ☐ Dr. _________________
   - ☐ Medications ____
   - ☐ Physical Therapy ____
   - ☐ Chiropractic Treatments _____________________________________
   - ☐ Cortisone injections ____
   - ☐ Surgery/ Procedures _______________________________________

6. Please list any diagnostic tests you have had relating to your problem (MRI, X-ray, EMG, etc.)

TEST/STUDY	DATE	RESULT
☐ X-ray ____________	________	______________________
☐ MRI ____________	________	______________________
☐ CT Scan ____________	________	______________________
☐ EMG ____________	________	______________________
☐ Other ____________	________	______________________

11. **PAST MEDICAL HISTORY** (Please circle any of the following with you have had)

Urinary Problems
Hypertension
Circulatory, Stroke
Diabetes, Hypoglycemia
Seizures
Kidney Problems
Cancer
Problems with Ears, Eyes, Nose, Throat
Heart Disease, chest pain, heart attack, irregular heart beat, valve
Respiratory Problems, Asthma, Hayfever, TB
Bleeding, Blood Clots, Transfusion Problems
Liver Problems, Jaundice, Hepatitis
Gastrointestinal Problems, Reflux,Ulcers, Diarrhea
Osteoarthritis, Rheumatoid, Psoriatic,Gout
Other Medical Disorders ______________________________

____

12. **PAST SURGICAL HISTORY** (Please list dates and type of surgeries)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

13. **CURRENT MEDICATIONS** (Please list Name and Dosage)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Allergies? ☐ Penicillin ☐ Sulfa ☐ Novocain ☐ Codeine ☐ Others ______________
What happens? ______________________________

14. **SOCIAL HISTORY**:
Occupation ______________
Marital Status __________ Children ______ Do you live alone? _______
Do you have a history of smoking? Packs/day ______ # of years ______ Date Quit__________
Do you drink alcoholic beverages? How often ____________ How much ____________
Do you have a history of substance abuse or addiction? ____________

15. **FAMILY MEDICAL HISTORY** (Any health conditions of Immediate Family Members?)
If yes, please describe:______________________________

____

16. Have you RECENTLY had any of the following? (please circle all that apply)

Fatigue
Depression
Heartburn
Sleep difficulty
Headaches
Nausea
Ulcers
Fainting
Weakness
Numbness
Difficulty Voiding
Loss of Appetite
Urinary Incontinence
Memory Loss
Shortness of Breath
Fever/Chills
Night Sweats
Stress
Itching
Chest Pain

Are you pregnant? Yes / No / Not Applicable

PATIENT HISTORY (PVT)

Name:________________________ Height:______ Weight:______ Left or Right Handed: L / R

Referred By: ____________________________

1. Mark the areas on your body where you feel pain or numbness/tingling:

When did symptoms first start? ____________________________

Are the symptoms getting: Worse Better No Change

Body parts affected: _____________________________________
____

Type of pain: Sharp Aching Throbbing Burning

Pain radiation (Describe): _________________________________
____

Pain rating (circle): **0** - 1 - 2 - 3 - 4 - **5** - 6 - 7 - 8 - 9 - **10**
No Pain Moderate Pain Severe pain

2. Do you have any other symptoms (numbness, dizziness, urinary incontinence, etc.)?
____

3. Do you have any weakness in your arms or legs? ____
____

4. Please describe any injury in detail: ____
____
____
____
____

5. Have you had these complaints evaluated or treated by another physician? If so, please list their names and treatments provided. Dr. ___________________ Dr. ___________________
Medications ____
Physical Therapy ____
Chiropractic Treatments ____
Cortisone injections ____
Surgery/ Procedures ____

6. Please list any diagnostic tests you have had relating to your problem (MRI, X-ray, EMG, etc.)

TEST/STUDY	DATE	RESULT
X-ray _______________	__________	____
MRI _______________	__________	____
CT Scan _____________	__________	____
EMG _______________	__________	____
Other _______________	__________	____

11. **PAST MEDICAL HISTORY** (Please circle any of the following with you have had)

Urinary Problems	Problems with Ears, Eyes, Nose, Throat
Hypertension	Heart Disease, chest pain, heart attack, irregular heart beat, valve
Circulatory, Stroke	Respiratory Problems, Asthma, Hayfever, TB
Diabetes, Hypoglycemia	Bleeding, Blood Clots, Transfusion Problems
Seizures	Liver Problems, Jaundice, Hepatitis
Kidney Problems	Gastrointestinal Problems, Reflux,Ulcers, Diarrhea
Cancer	Osteoarthritis, Rheumatoid, Psoriatic,Gout

Other Medical Disorders ____
____

12. **PAST SURGICAL HISTORY** (Please list dates and type of surgeries)

_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________

13. **CURRENT MEDICATIONS** (Please list Name and Dosage)

_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________

Allergies? Penicillin Sulfa Novocain Codeine Others _______________________
What happens? ____

14. **SOCIAL HISTORY**:
Occupation ___________________________
Marital Status __________ Children ______ Do you live alone? _______
Do you have a history of smoking? Packs/day ______ # of years ______ Date Quit__________
Do you drink alcoholic beverages? How often ______________ How much ________________
Do you have a history of substance abuse or addiction? ______________

15. **FAMILY MEDICAL HISTORY** (Any health conditions of Immediate Family Members?)
If yes, please describe:____
____

16. Have you RECENTLY had any of the following? (please circle all that apply)

Fatigue	Nausea	Difficulty Voiding	Fever/Chills
Depression	Ulcers	Loss of Appetite	Night Sweats
Heartburn	Fainting	Urinary Incontinence	Stress
Sleep difficulty	Weakness	Memory Loss	Itching
Headaches	Numbness	Shortness of Breath	Chest Pain

Are you pregnant? Yes / No / Not Applicable