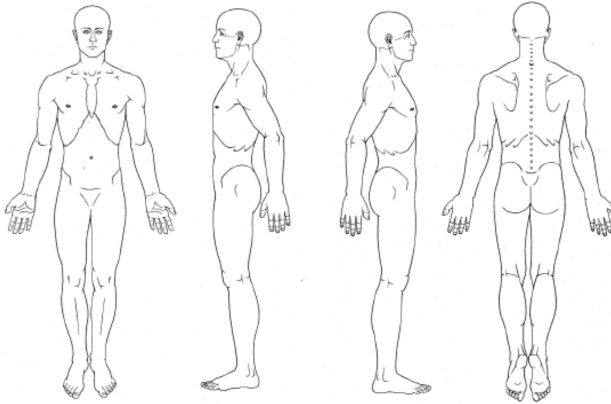
HISTORY OF PRESENTING ILLNESS (HPI)

Name ______________________________ Date of Birth_____/_____/________ **Referring Physician** ________________________

Family Physician (PCP) ____________________ PCP Office location ___________________ Last visit to PCP _____/_____/_____

Where is your pain? ____

Office Use Only
Ht. ____′ ______″
Wt. _______ lbs.
BMI _______
BP ______/______
Pulse ________ bpm
Resp. ________ cpm
Temp. _________° F



What does your pain feel like? ❑ Burning ❑ Sharp ❑ Stabbing ❑ Dull Ache ❑ Throbbing ❑ Tingling ❑ Numb ❑ Shooting

During the past 4 weeks, indicate the severity of your symptoms on a 0-10 scale: 0 = (no pain) 10 = (most severe) ______/10

When did it begin? ____________________ **What do you think caused the problem?** ___________________________________

What time of day is the pain present? ❑ Upon waking ❑ Afternoon ❑ Evening ❑Night/During Sleep

How often do you experience your symptoms? ❑ Constantly (76-100% of the day) ❑ Frequently (51-75% of the day)
❑ Occasionally (26-50% of the day) ❑ Intermittently (0-25% of the day)

Do you have any other symptoms you think are related to this problem? (arm/leg numbness, etc.) ❑ Yes ❑ No If Yes, where…
____

During the past 4 weeks, how much of the time has your condition interfered with your daily activities?❑ All of the time ❑ Most of the time ❑ Some of the time ❑ A little of the time ❑ None of the time

Have you had similar symptoms in the past? ❑ Yes ❑ No If Yes, when ____

If you received treatment for the same or similar symptoms in the past, who did you see? ❑ This office ❑ Other Chiropractor ❑ MD/DO ❑ Physical Therapist …. and **WHEN** _______________

What test(s) have you had for your symptoms? ❑ **None** ❑ X-rays ❑ MRI ❑ CT Scan ❑ EMG/NCV study ❑ Other ________

When were these tests done? ❑ The past month ❑ 2-3 months ago ❑ 3-6 months ago ❑ 6 months - 1 yr ago ❑ 1-2 yrs ago

Where were these tests completed? _______________________________

In general, would you say your overall health right now is… ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Patient Signature ____ Date ______/______/______

PAST MEDICAL& SOCIAL HISTORY

Name ____ DOB _____/_____/________

Have you ever (at any time) experienced any of the following?

	Yes	No
Difficulty Urinating	❑ -	❑ -
Loss of bladder control	❑ -	❑ -
Loss of Bowel control	❑ -	❑ -
Temp. loss of vision, One eye	❑ -	❑ -
Blood in urine	❑ -	❑ -
Claustrophobia	❑ -	❑ -
Spinal surgery	❑ -	❑ -
Common cold/Flu	❑ -	❑ -
Carotid Artery surgery	❑ -	❑ -
Breast removal	❑ -	❑ -

Have you ever been diagnosed with or told you have one of the following?

	Yes	No
Detached retina	❑ -	❑ -
Stroke	❑ -	❑ -
Slipped disc	❑ -	❑ -
Herniated disc	❑ -	❑ -
Osteoporosis	❑ -	❑ -
TIA's (mini strokes)	❑ -	❑ -
Drop Attacks (collapsing only)	❑ -	❑ -
Hardening of Arteries	❑ -	❑ -
Partial or complete paralysis	❑ -	❑ -
Rheumatoid Arthritis	❑ -	❑ -
Fractured/broken vertebra	❑ -	❑ -
Bleeding disorders	❑ -	❑ -
High blood pressure	❑ -	❑ -
Blood in stool	❑ -	❑ -
Cancer	❑ -	❑ -
AIDS	❑ -	❑ -
Kidney Disease	❑ -	❑ -
Prostate Disease	❑ -	❑ -

Do you currently have, or could you be, any of the following?

	Yes	No
Pregnant	❑ -	❑ -
Taking birth control pills	❑ -	❑ -
Receiving radiation therapy	❑ -	❑ -
Taking blood thinners	❑ -	❑ -
A heavy smoker (1 or more packs a day)	❑ -	❑ -
Alcohol/Drug Dependence	❑ -	❑ - _____/day

In the past 14 days, have you experienced the following?

	Yes	No
Nausea	❑ -	❑ -
Vomiting	❑ -	❑ -
Vertigo	❑ -	❑ -
Difficulty walking	❑ -	❑ -
In-coordination	❑ -	❑ -
Numbness/Tingling	❑ -	❑ -
Loss of consciousness	❑ -	❑ -

Surgical/medical implanted devices:

	Yes	No
Aortic Clips	❑ -	❑ -
Brain clips	❑ -	❑ -
Artificial heart valves	❑ -	❑ -
Rods, pins, screws	❑ -	❑ -
IUD	❑ -	❑ -
Surgical clips/wires	❑ -	❑ -
Shunts	❑ -	❑ -
Neuro-stimulator	❑ -	❑ -
Dentures	❑ -	❑ -
Hearing Aid	❑ -	❑ -
Pacemaker	❑ -	❑ -
Insulin Pump	❑ -	❑ -
Joint Replacement	❑ -	❑ -
Cochlear Implant (ear)	❑ -	❑ -

Other Implanted Devices:

	Yes	No
Metal Fragments	❑ -	❑ -
Bullets/Shrapnel	❑ -	❑ -
Body piercing	❑ -	❑ -
Tatoos	❑ -	❑ -

List current medications (**or** <u>none</u>):

____

____

____

List all drug/food allergies (**or** <u>none</u>):

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Patient Signature ____________________________________ Date ______/______/______