

NAME: _____

DATE: _____

A. HAVE YOU EVER HAD:	YES	NO
1. Heart Disease or Heart Attack	_____	_____
2. Lung Disease	_____	_____
3. Stomach or Bowel Problems	_____	_____
4. Circulation Problems	_____	_____
5. Diabetes	_____	_____
6. High Blood Pressure	_____	_____
7. Cancer	_____	_____
8. Thyroid Problems	_____	_____
9. HIV	_____	_____
10. AIDS	_____	_____

If yes, please explain _____

B. CHIEF COMPLAINT: WHY ARE YOU HERE TODAY? _____

Date of injury or onset of pain: _____

C. PAST SURGERIES: _____

D. CURRENT MEDICATIONS: _____

E. PAST NECK OR BACK INJURY: _____

F. ALLERGIES TO MEDICATIONS: _____

G. SOCIAL HISTORY: Occupation: _____

Married _____ Children _____ Height _____ Weight _____
Smoke _____ How Much? _____ Alcohol _____ How Much? _____

H. RECENT X-RAYS: YES NO (Please circle)

Where taken? _____