KEIPER SPINE

PATIENT HEALTH HISTORY FORM

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PATIENT INFORMATION

Primary reason for your visit? _____

Name: _____DOB: _____Occupation: _____

Email Address: _____Ethnicity: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic

Referring Doctor: _____ Primary Doctor: _____

Disability? Y / N Since: _____ Disability Provider: _____

MEDICATION/ALLERGIES *PLEASE BRING A LIST OF CURRENT MEDICATIONS TO APPOINTMENT*

Are you on any blood thinning medications? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Xarelto ☐ Eliquis ☐Pradaxa

☐ Effient ☐Other_____ Allergies_____

MOST RECENT IMAGING

When: _____Where: _____What: _____

When: _____Where: _____ What: _____

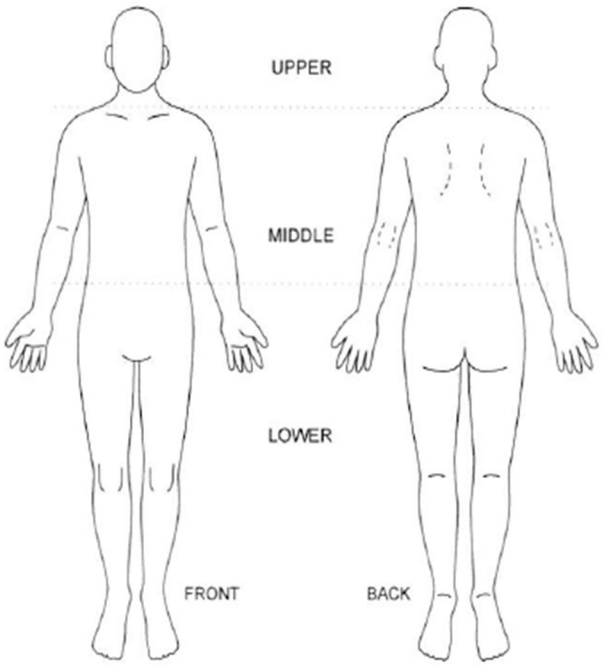
SYMPTOMS Describe your symptoms. Please fill out and use the diagram below to assist you in your description.

*Mark on the drawing according to where you hurt. Please indicate on the drawing where you feel any of the following symptoms by placing the marks shown here on the **DIAGRAM KEY.***

DIAGRAM KEY:

Numbness=**N** Ache=**A** Weakness=**W**

Burning=**B** Stabbing=**S** Pins & Needles=**P**



How long have you had these symptoms? _____

Average pain score (0=no pain to 10=worst)? _____

Do you have any weakness? ☐ Yes ☐ No

Where: _____

Do you have numbness/tingling? ☐ Yes ☐ No

Where: _____

What makes your pain better?

☐ Laying ☐ Sitting ☐ Standing ☐ Walking ☐ Rest ☐ Heat

☐ Ice ☐ Position change ☐ NSAIDs (ibuprofen, Celebrex, etc.)

☐ Narcotics (name): _____

What makes your pain worse?

☐ Laying ☐ Sitting ☐ Standing ☐ Walking ☐ Twisting ☐ Lifting

☐ Pushing/pulling ☐ Sit to stand ☐ Getting out of bed ☐ Carrying

Previously tried treatment(s):

☐ Physical therapy ☐ Helped? Yes (how long?) _____ ☐No

☐ Steroid injections ☐ Helped? Yes (how long?) _____ ☐No

Other therapies:

☐ Chiropractic/massage ☐ Exercise ☐ Aquatic ☐ Acupuncture

Is this the result of a specific injury or accident? ☐ Yes ☐ No Date of accident_____

Are you involved in litigation regarding this condition? ☐ Yes ☐ No Type of accident _____

MEDICAL HISTORY (Check all that apply)

☐Atrial Fibrillation ☐Cancer ☐Hepatitis B/C ☐Neuropathy
☐Anemia ☐Depression ☐Hernia ☐Obesity
☐Brain Aneurysm ☐Diabetes ☐High Cholesterol ☐Osteoporosis
☐Anxiety Disorder ☐GERD ☐Hypertension ☐Pacemaker
☐Arthritis ☐HIV or AIDS ☐Kidney Disease ☐Peripheral Vascular Disease
☐Asthma ☐Head Trauma/Injury ☐Liver Disease ☐Pulmonary Embolism
☐Back Problems ☐Headaches/Migraines ☐Lung Disease ☐Seizure/Epilepsy
☐Bleeding Disorder ☐Heart Attack (MI) ☐Multiple Sclerosis ☐Sleep Apnea
☐CAD ☐Aortic Aneurysm ☐Muscle/Joint/Bone Pain ☐Stroke
☐COPD ☐Neck Injury ☐Thyroid Problems

Past Neck/Back Surgical History:
Neck: Date: _____ Procedure: _____ Doctor: _____
Back: Date: _____ Procedure: _____ Doctor: _____

Family Health History: Place the letter of your family member relationship that has a condition listed below.
M-mother, **F**-father, **B**-brother, **S**-sister, **MGM**-maternal grandmother, **MGF**-maternal grandfather, **PGM**-paternal grandmother, **PGF**-paternal grandfather

Addiction _____ Heart Attack _____ Back Problems _____
Cancer _____ Osteoporosis _____ Bleeding Disorder _____
Hypertension _____ Alzheimer's _____ Rheumatoid Arthritis_____
Multiple Sclerosis _____ Diabetes_____

Do you presently have any problems or symptoms in the following areas?

☐Numbness/tingling sensation ☐Chronic cough ☐Lack of bladder control
☐Muscle weakness ☐Shortness of breath ☐Change in sexual function
☐Difficulty walking ☐Coughing up blood ---
☐Seizures ☐Voice changes ☐Recurrent fever, chills, sweats
☐Headaches ☐Chronic sinus problems ☐Recent weight loss
☐Change of Vision --- ☐Enlarged lymph nodes
☐Depression ☐Abdominal pain ☐Extreme fatigue
☐Nervousness ☐Vomiting blood ☐Excessive thirst
--- ☐Frequent diarrhea ☐Easy bruising
☐Chest pain ☐Severe heart burn ☐Frequent bleeding
☐Irregular heart beat ☐Constipation ☐Abnormal mole
--- --- ☐Skin rash
☐Environmental allergies ☐Excessive urination
☐Heat or cold intolerance ☐Burning with urination

SOCIAL HISTORY

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed
Tobacco Use: ☐Yes ☐No _____# packs per day Since_____
Former smoker? ☐Yes ☐No Year quit? _____
Alcohol Use: ☐Yes ☐No _____# drinks per day week month
Recreational Drug Use: ☐Yes ☐No
How often and what substance? _____
Exercise: ☐Yes ☐No ☐Occasional ☐Moderate ☐Frequent

LIVING SITUATION

Do you live alone? ☐Yes ☐No

If you need surgery, do you have someone who can assist you in your recovery?
☐Yes ☐No

I attest that all information I provided is true and correct to the best of my knowledge:

Patient's signature: _____Date: _____