



Name:	DOB:	Age:	Date:
Address:	City:	State:	Zip:
Phone:	Email:		
Occupation:	In case of emergency, contact:		
Your Doctor:	Relationship to you:		
Who may we thank for your referral?	Home phone:	Work phone:	

Reason for visit:			When did your symptoms appear?			
Is it getting:	☐ Better	☐ Worse	☐ No change	How often do you have pain?		
Type of pain:	☐ Sharp	☐ Dull	☐ Throbbing	Mark an X on the picture below where you have pain, numbness, or tingling.		
	☐ Numb	☐ Aching	☐ Shooting			
	☐ Burning	☐ Tingling	☐ Cramping			
	☐ Stiff	☐ Swollen	☐ Other			
Is your pain:	☐ Constant	☐ Intermittant				
Does it interfere:	☐ Work	☐ Sleep	☐ Recreation			
	☐ Daily routine					
Makes it worse:	☐ Sitting	☐ Standing	☐ Walking			
	☐ Bending	☐ Lifting	☐ Laying down			

Marital Status:	Work Activity:	Exercise:	Habits:
☐ Single	☐ Sitting	☐ None	☐ Smoking, packs/day
☐ Married	☐ Standing	☐ Minimal	☐ Alcohol, drinks/week
☐ Divorced	☐ Light labor	☐ Moderate	☐ Coffee/caffeine, cups/day
☐ Widowed	☐ Heavy labor	☐ Intense	☐ High stress, reason:
☐ Minor	☐ Repetitive motions	☐ Daily	☐ Sleep, hours/night

[illegible]

HEALTH HISTORY

What treatments have you already received for your condtion: ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Massage ☐ Chiropractic ☐ Acupuncture ☐ Other: _____

Imaging and Diagnostic Testing: (please list when and where you have had the following)

X-Ray: _____
Ultrasound: _____
MRI / CAT scans: _____
Bone Scan: _____
Blood test: _____
Other: _____

Review of Systems: (Check Y for yes and N for no for each of the following conditions)

AIDS/HIV	☐ Y ☐ N	Emphysema	☐ Y ☐ N	Mumps	☐ Y ☐ N
Alcoholism	☐ Y ☐ N	Epilepsy	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N
Allergies	☐ Y ☐ N	Fatigue	☐ Y ☐ N	Parkinson's disease	☐ Y ☐ N
Anemia	☐ Y ☐ N	Fractures	☐ Y ☐ N	Pneumonia	☐ Y ☐ N
Anxiety	☐ Y ☐ N	Glaucoma	☐ Y ☐ N	Polio	☐ Y ☐ N
Alzheimer's disease	☐ Y ☐ N	Goiter	☐ Y ☐ N	Rheumatoid arthritis	☐ Y ☐ N
Appendicitis	☐ Y ☐ N	Gout	☐ Y ☐ N	Sickle cell	☐ Y ☐ N
Arthritis	☐ Y ☐ N	Headaches	☐ Y ☐ N	STDs	☐ Y ☐ N
Asthma	☐ Y ☐ N	Heart attack	☐ Y ☐ N	Stroke	☐ Y ☐ N
Bleeding disorders	☐ Y ☐ N	Heart disease	☐ Y ☐ N	Suicide attempt	☐ Y ☐ N
Breast cancer	☐ Y ☐ N	Hepatitis	☐ Y ☐ N	Thyroid problems	☐ Y ☐ N
Colon cancer	☐ Y ☐ N	Hernia	☐ Y ☐ N	Tonsilitis	☐ Y ☐ N
Prostate cancer	☐ Y ☐ N	Herniated disc	☐ Y ☐ N	Trouble sleeping	☐ Y ☐ N
Other cancer	☐ Y ☐ N	High blood pressure	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Bronchitis	☐ Y ☐ N	High cholesterol	☐ Y ☐ N	Tumors	☐ Y ☐ N
Bulemia	☐ Y ☐ N	IBS	☐ Y ☐ N	Ulcers	☐ Y ☐ N
Cataracts	☐ Y ☐ N	Kidney disease	☐ Y ☐ N	Varicose veins	☐ Y ☐ N
Chicken pox	☐ Y ☐ N	Liver disease	☐ Y ☐ N	Weight loss	☐ Y ☐ N
COPD	☐ Y ☐ N	Mental illness	☐ Y ☐ N		
Depression	☐ Y ☐ N	Migraines	☐ Y ☐ N		
Diabetes	☐ Y ☐ N	Multiple sclerosis	☐ Y ☐ N		

This history has been designed to facilitate our patients continuity of care at Taylor Health. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your written authorization to do so.

I certify that the above information, both written and verbal, provided here in this form and to Taylor Health is true and accurate to the best of my knowledge. Parent/Guardian signature required if patient is under 18 years of age.

_____ Patient Name (Print)	_____ Patient Signature	_____ Date
_____ Parent/Guardian Name (Print)	_____ Parent/Guardian Signature	_____ Date