INTEGRATED MEDICAL

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Comprehensive Health History Form

Patient Information

First Name

Middle Name / MI

Last Name

Patient Address Line 1

Patient Address Line 2

City

State

Zip

Home Phone

Cell Phone

Work Phone

Preferred Phone

Email

Sex

Date of Birth

Age

Marital Status

Other

Professional Title

Employer Name

In Case of Emergency

Emergency Contact Name

Emergency Contact Relationship to Patient

Emergency Contact Home Phone

Emergency Contact Cell Phone

How Did You Hear About Us?

- ◯ Referral
- ◯ Internet
- ◯ Direct Mail
- ◯ Magazine
- ◯ Other

Referral:

Other:

Current Condition

What is/are your chief complaint(s)?

Problem

- ◯ Head
- ◯ Neck
- ◯ Shoulder
- ◯ Hand
- ◯ Upper Back
- ◯ Mid Back
- ◯ Low Back
- ◯ Hip
- ◯ Knee
- ◯ Ankle
- ◯ Foot
- ◯ Other

Severity

◯ Least 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6
◯ 7 ◯ 8 ◯ 9 ◯ 10 Most

When did the condition(s) begin?

_____

How often do you have this pain?

_____

Has it occurred before?

◯ Yes ◯ No

When?

_____

Is the condition getting worse?

◯ Yes ◯ No ◯ Unknown

Does it interfere with

☐ **Work** ☐ **Sleep** ☐ **Daily Routine**
☐ **Recreation**

Is the Condition:

◯ Auto Related ◯ Job Related
◯ Home Injury ◯ Slip/Fall ◯ Lifting
◯ Slept Wrong ◯ Unknown Cause
◯ Other

Other:

_____

What treatment have you received for your condition?

☐ **Medication** ☐ **Surgery**
☐ **Physical Therapy**
☐ **Chiropractic Services** ☐ **None**
☐ **Other**

Other

_____

Success

◯ Excellent ◯ Good ◯ Fair

Additional Problem

- ◯ Head
- ◯ Neck
- ◯ Shoulder
- ◯ Hand
- ◯ Upper Back
- ◯ Mid Back
- ◯ Low Back
- ◯ Hip
- ◯ Knee
- ◯ Ankle
- ◯ Foot
- ◯ Other

Severity

◯ Least 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6
◯ 7 ◯ 8 ◯ 9 ◯ 10 Most

What treatment have you received for your condition?

☐ **Medication** ☐ **Surgery**
☐ **Physical Therapy**
☐ **Chiropractic Services** ☐ **None**
☐ **Other**

Other

_____

Success

◯ Excellent ◯ Good ◯ Fair

Please indicate the CURRENT TYPE of Discomfort:

Accident Information

Do you currently have an active accident claim?

◯ Yes ◯ No

Date

Type of Accident

◯ Auto ◯ Work ◯ Home ◯ Other

Other

To whom have you made a report of your accident?

☐ **Auto Insurance** ☐ **Employer**
☐ **Work Comp** ☐ **Other**

Other

Attorney Name

Current Medications

Do you take medications?

☐ I take the medications listed below.
☐ I do not take any medications.

Medication	**Dosage/How Long**	**For What Condition?**
Medication	**Dosage/How Long**	**For What Condition?**

Allergies

☐ I have the allergies listed below.
☐ I do not have any allergies.

Medication Allergies:	**Reaction?**
Supplement Allergies:	**Reaction?**
Food Allergies:	**Reaction?**

Do you have any surgical devices in your body? (ie screws, pins, plates, etc)

◯ Yes ◯ No

If yes, where located

Current Herbal Medications

Medication	**Dosage/How Long**	**For What**
Medication	**Dosage/How Long**	**For What**
Medication	**Dosage/How Long**	**For What**

Other Medications

Please List Previous Medications (Last 10 Years)

Medication	Dosage/How Long	For What

Have your medications or supplements ever caused you unusual side effects or problems?

◯ Yes ◯ No

Describe:

Have you ever had prolonged or regular use of:

NSAIDS (Advil, Aleve, etc.), Motrin or Aspirin?

◯ Yes ◯ No

Tylenol?

◯ Yes ◯ No

Acid Blocking Drugs (Tagament, Zantac, Prilosec)?

◯ Yes ◯ No

Frequent Antibiotics (> 3 times a year)

◯ Yes ◯ No

Long Term Antibiotics

◯ Yes ◯ No

Steroids Present or Past (Prednisone, Nasal Allergy Inhalers)

◯ Yes ◯ No

Lifestyle History

Check Your Exercise Levels:

◯ Inactive ◯ Light Activity ◯ Moderate Activity ◯ Heavy Activity ◯ Vigorous Activity

Please select all that apply:

Patient Smoking Status

Patient Smoking Frequency

Are you exposed to 2nd hand smoke regularly?

Alcohol

Drinks/Week

Coffee/Caffeine Drinks

Cups/Day

Do you currently or have previously used recreational drugs?

◯ Yes ◯ No

If yes, what types/method (IV, inhaled, smoked, etc)

Work Activity

Labor Activity

◯ Light ◯ Moderate ◯ Heavy ◯ Sedentary

Work Activity Postures

- ☐ Bending
- ☐ Pushing
- ☐ Twisting
- ☐ Pulling
- ☐ Climbing
- ☐ Reaching
- ☐ Walking
- ☐ Standing
- ☐ Kneeling
- ☐ Sitting
- ☐ Computer
- ☐ Repetitive

Work Activity Level

- ◯ Full-Time
- ◯ Part-Time
- ◯ Homemaker
- ◯ Student
- ◯ Unemployed

Hours per week

_____

Mostly

- ◯ Sitting
- ◯ Walking
- ◯ Standing

Work Environment

- ◯ Difficult
- ◯ Enjoyable
- ◯ Relaxed
- ◯ Stressful

Medical History

Please check all that apply

Surgeries

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- ☐ N/A
- ☐ Appendectomy
- ☐ Cardiac Bypass
- ☐ C-Section
- ☐ Cosmetic
- ☐ Gall Bladder
- ☐ Implants
- ☐ Lasik
- ☐ Tonsillectomy
- ☐ None Reported
- ☐ Bunionectomy
- ☐ Cataracts
- ☐ Carpal Tunnel
- ☐ Ear Tubes
- ☐ Hysterectomy
- ☐ Knee
- ☐ Spinal Fusion
- ☐ Wisdom Discectomy

(Indicate what year)

_____

Injuries

- ☐ Back Injury
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Soft Tissue
- ☐ Broken Bones/Fractures
- ☐ Industrial
- ☐ Severe Fall
- ☐ Other

Injuries

_____