CORE SERVICES
PATIENT HISTORY SHEET

NAME: _____ Date: _____ Age: _____

SSN: _____ Occupation: _____

Briefly describe your condition/the purpose for your visit: _____

_____

When did this begin? _____

Is this condition related to: € injury on the job € motor vehicle accident € athletic injury

Have you had any other treatment for your condition? € No € Yes (check all that apply)

€ Medication	€ CT Scan	€ Bone Scan	€ Physical Therapy
€ Injection	€ MRI	€ Surgery	€ Biofeedback
€ X-Ray	€ EMG/NCV	€ Chiropractic	€ Massage

€ Other: _____

Do you now have, or have you had, any of the following:

€ Asthma	€ Heart problems	€ Fractures
€ Respiratory problems	€ Heart attack	€ Broken bones
€ Arthritis	€ Stroke	€ Implants
€ Swelling at joints	€ High blood pressure	€ Surgery
€ Occasional headaches	€ Heart disease	€ Nervous disorders
€ Chronic headaches	€ Pacemaker	€ Depression
€ Sensitivity to light	€ Hearing problems	€ Sleep disorder
€ Sensitivity to noise	€ Visual problems	€ Diabetes
€ Sensitivity to heat	€ Kidney problems	€ Back pain
€ Sensitivity to cold	€ Skin disorders	€ Neck pain
€ Dizziness	€ Stomach disorders	For females:
€ Fatigue	€ Hernia	€ gynecological problems
€ Seizures	€ Gallbladder problems	For males:
€ Unexplained weight loss	€ Cancer	€ prostate problems

For females: Are you pregnant? € No € Yes

Other conditions &/or problems not listed: _____

Do you have any allergies? € No € Yes

If you have allergies, please list any food and/or drug allergies:_____

_____

Are you presently taking any medication? € No € Yes

If yes, please list what medication you are taking and the condition it is prescribed for:

_____

_____

Comments: _____

_____