

# PATIENT HEALTH HISTORY

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Chief Complaint / Current Problems:  
(eg., headaches, back, neck, arm, leg, or hand pain etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long have you been experiencing this pain ? (use chart below)

SYMPTOMS:	DURATION:

Are you currently out of work or on a light duty status for this condition ? If yes please explain. \_\_\_\_\_

\_\_\_\_\_

First day out of work due to this

disability: \_\_\_\_\_

How have you had to alter your life style due to your condition. (ie: housework, sports etc.)

\_\_\_\_\_

\_\_\_\_\_

If this problem is the result of an accident or Injury, Is there any litigation as a result of it. (eg.: Motor Vehicle, Workmens compensation law suit.)

\_\_\_\_\_

Date of Injury: \_\_\_\_\_

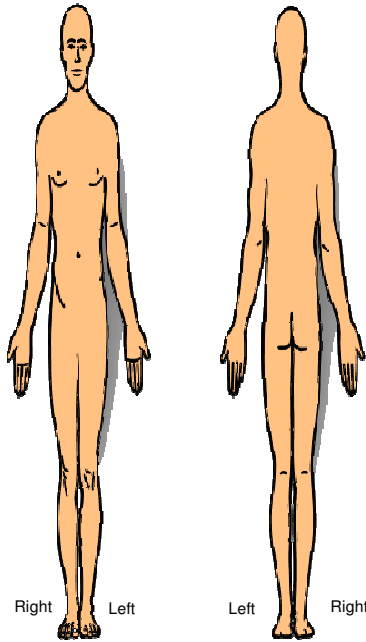
Have you ever been involved in a law suit against a healthcare provider ? If so please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Where is your pain now:** Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.



**For ache use:** ^^^^^^

**For numbness use:** ooooo

**For tingling/pins & needles use:** ++++

**For Burning use:** xxxx

**For Radiating Pain:** / / / / /

**On a VA Scale of 0-10 how is your back /neck pain now ?**

\_\_\_\_\_

How bad is your extremity pain now ?

\_\_\_\_\_

I can tolerate my pain at a pain score of ?

\_\_\_\_\_

**Please Circle the duration of Pain:**

Continuous

Positional

Intermittent (on/off)

Unable to rate

**Referred By:**

Physician: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Internist/Primary Care Physician:**

Physician: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Other Doctor(s) involved in your care:**

Physician: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**RN Case Manager (if applicable):**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**If you are represented by an attorney please provide his/her name, address, phone and fax for our records:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_