

CONFIDENTIAL PATIENT HEALTH RECORD

DATE

FILE NUMBER

Please answer the following questions as completely as possible so that we may understand your problem and recommend appropriate solutions.

SECTION A: Personal History

Name	_____						
Address	_____						
	Postal Code	_____					
Date of Birth	Home Phone	_____					
Occupation	Business Phone	_____					
Health Care Number	E-Mail	_____					
Marital Status	S	M	W	S	D	Name of Spouse	_____
Number of Children	Who referred you to the office						

SECTION B: For Worker's Compensation or Motor Vehicle Collision Cases Only

Date & Time of Accident	_____				
Details of Accident	_____				
Insurance Company	_____	Phone Number	_____		
Claim Number	_____	Claims Contact	_____		
Have you lost any days from work?	YES	NO	Did you report this accident to your employer?	YES	NO
Position Description:	_____				
What are your essential job duties	_____				
Employer	_____				
Employer's Address	_____				
Phone Number	_____				

SECTION C: Current Health Condition

Major complaint	_____			
When did it begin	_____			
Has it occurred before	NO	YES	EXPLAIN	_____
Other treatment for this condition	_____			
What aggravates your condition	_____			
What relieves your condition	_____			
Describe the nature or quality of your symptoms	_____			
Does pain, tingling or numbness refer or radiate to your arms, hands, legs or feet	NO	YES		
Describe	_____			
Is the condition getting worse	NO	YES	CONSTANT	VARIABLE
Does this condition wake you up at night	NO	YES	SOMETIMES	
After a night's sleep are you	BETTER	WORSE	NO DIFFERENCE	
Please list medications or drugs you are taking	_____			
FEMALES ONLY	Are you pregnant	NO	YES	
	Have you ever had silicone breast implants	NO	YES	

VISUAL ANALOGUE PAIN SCALE

Please mark on the line to indicate how severe your pain has been in the past week

(or less if acute case)

NO PAIN

(slight)

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PAIN AS BAD
AS IT COULD BE

(severe)

THIS IS A 5-PAGE FORM.