Integrated Health Solutions

Health History

Patient Name:____Date:_________________ .__

SS#:______________________DOB:__________ Gender:____________Phone:__________________

Minor? Yes No Marital Status _____________

Employer: ____

Spouse or patients guardian name: ____

Emergency
Contact:______________________________________Phone;________________________

Past Medical History/Illness

Have you been diagnosed with a
disease?___________________________Types:____

____

Previous injuries (specific please)____

____

Patient Social History

Use of Alcohol: Never:__________ Rarely:_______ Moderate:_________ Daily:_______
Use of Tobacco: Never:__________ Rarely:_______ Moderate:_________ Daily:_______
Use of Drugs: Never:__________ Rarely:_______ Moderate:_________ Daily:_______
Over the counter medications:____
Medications:____

____
Previous Surgeries:____
Disorders (please circle): Fibromyalgia IBS Migraine Insomnia Acid Reflux Neuropathy

Family Medical History:

Father:_________________Mother______________Siblings____________Children_________

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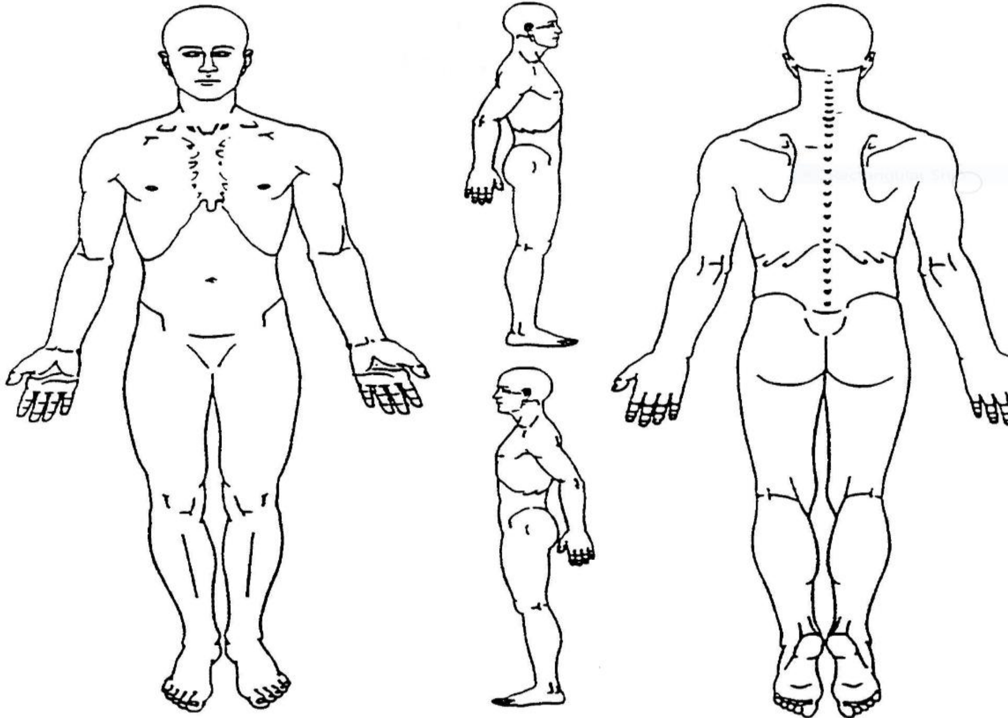
Chief Complaint:____
History of present illness:____
Location of problem:____

Please draw and explain accurately, descriptions below:



What does your pain feel like?____
Is your symptom constant?____
Have you been diagnosed by anyone?____
Why do you think your problem exists?____
How did your problem start?____
Did you have an injury first?____
Did your symptoms "come out of nowhere"?_______________________________________
What do you do to help control the symptoms?____________________________________
When do the symptoms come on?____
Have you recognized any connection between when the pain starts and what you are doing right before?
____
How long can you walk without *any symptoms?*______________________________
What activities cause the most symptoms?_______________________________
Do quick movements cause more symptoms?_________________________________
Can you still run/jump/squat/kneel?_______________________________________

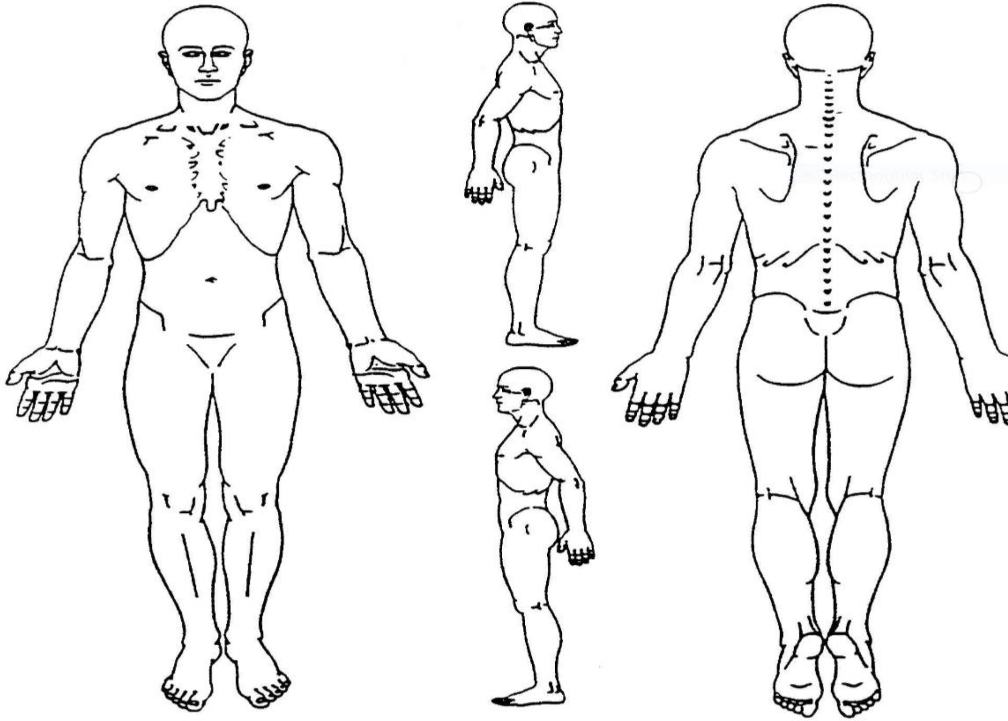
We will likely discuss all these ideas deeper during your exam. Thank you

Second Complaint:____

History of second complaint:____

Location of problem:____

Please draw and explain accurately, descriptions below:



What does your pain feel like?____

Is your symptom constant?____

Have you been diagnosed by anyone?____

Why do you think your problem exists?____

How did your problem start?____

Did you have an injury first?____

Did your symptoms "come out of nowhere"?____

What do you do to help control the symptoms?____

When do the symptoms come on?____

Have you recognized any connection between when the pain starts and what you are doing right before?

____

How long can you walk without *any symptoms?*____

What activities cause the most symptoms?____

Do quick movements cause more symptoms?____

Can you still run/jump/squat/kneel?____

We will likely discuss all these ideas deeper during your exam. Thank you