



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: _____

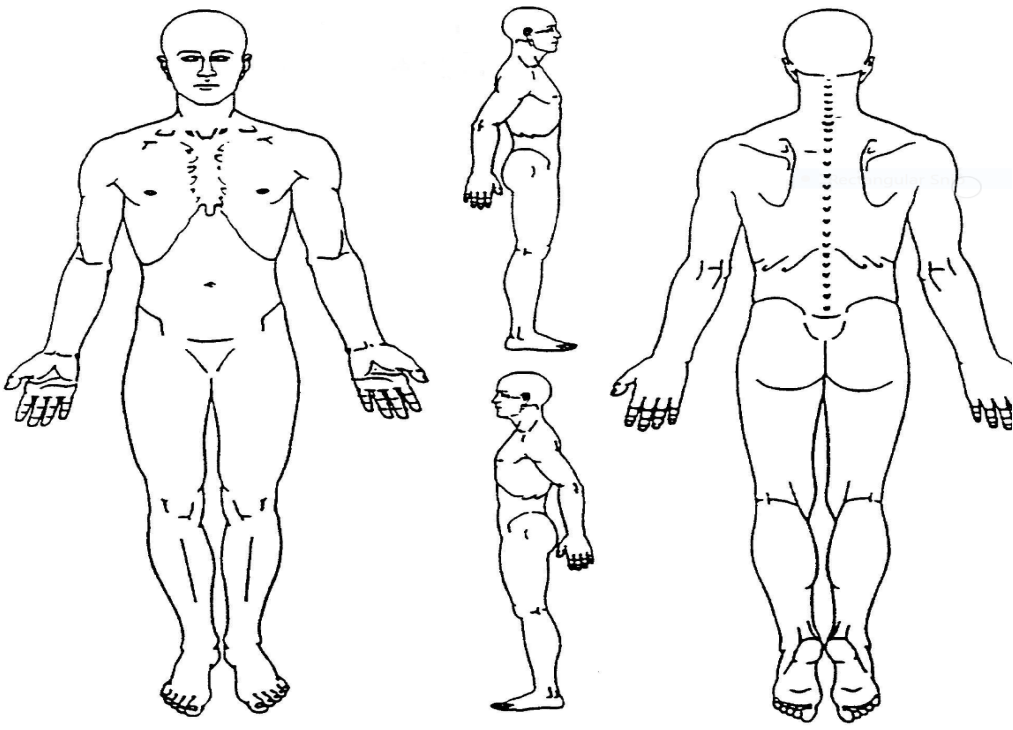
Disorders (please circle): Fibromyalgia IBS Migraine Insomnia Acid Reflux Neuropathy

Family Medical History:

Father: _____ Mother _____ Siblings _____ Children _____

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? _____

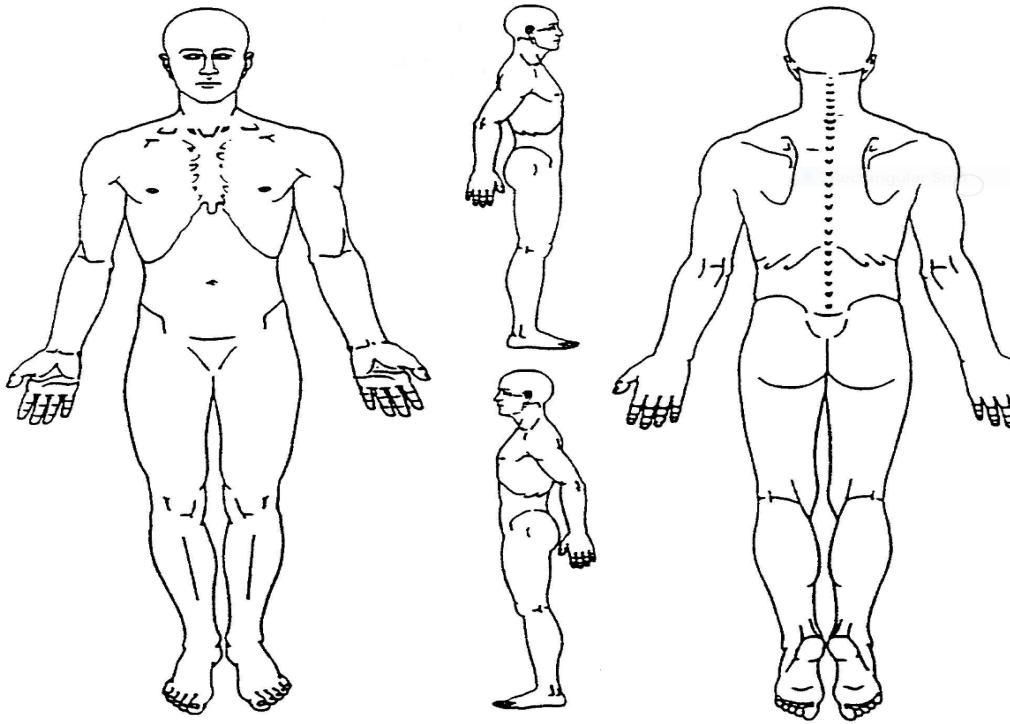
We will likely discuss all these ideas deeper during your exam. Thank you

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