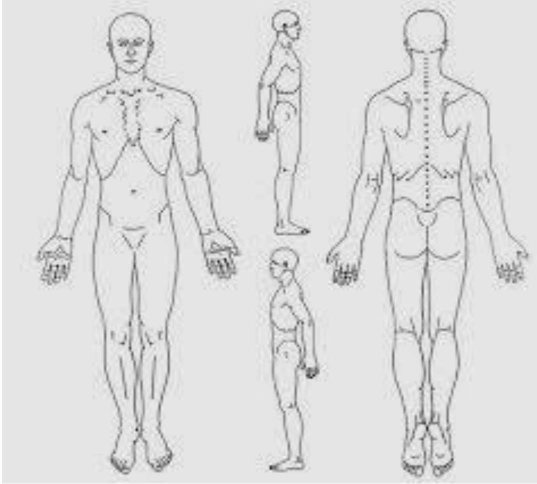
History Form

History of the current problem

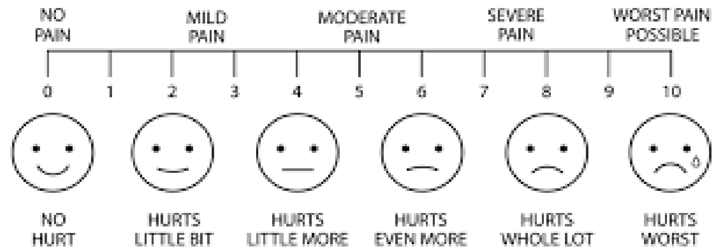
Where is the pain? Please mark or circle the area



Is your pain? ☐ Dull ☐ Achy ☐ Sharp ☐ Shooting

☐ Throbbing ☐ Numb ☐ Tingling ☐ Weakness

Rate your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain imaginable



Is the pain getting better or worse overtime? ____

Does the pain travel to other parts of the body? ____

Does anything relieve the pain? ____

Does anything make the pain worse? ____

Past History

List the dates and types of ANY surgeries: ____

____

List the dates and reasons for any hospitalizations: ____________________________________

____

List the dates and severity of ANY automobile accidents (include fender benders): ____________

____

____

List any sports you play/played and any injuries: ______________________________________

____

List the dates and describe injuries from ANY falls: ____________________________________

____

List the dates and any incidence of major impacts to the head: ___________________________

____

List the dates and type of ANY major illnesses: _______________________________________

____

Females: list any problems with PMS or menstrual cycle: ________________________________

____

What was your birth like? ____

Family History

List your siblings, their ages, and any health issues: ____________________________________

Health of your parents: ____

Health of your grandparents: ____

____

History Form Page 2

Medical/Social History

How many times in your life have you taken antibiotics? ____
Have you taken them recently/why? ____
Did you take probiotics while taking antibiotics? ____
Do you smoke cigarettes? If yes, how much and for how long? ____
If you are an ex-smoker, when did you quit and how long did you smoke? ______________________________
Do you smoke marijuana? If yes, for what and for how long? ____
Do you drink alcohol? If yes, how much and how often? ____
If you are sober, when did you quit and how long did you drink? ______________________________________
Do you do any recreational drugs? If yes, what do you use, how much, how often and for how long?
____
If you used to do drugs, when did you quit and what did you use? ______________________________________

What are your hobbies? ____
____

What kind of exercise do you do and how often? ____
____

What do you do when you are stressed? ____
____

How many hours/day and days/week do you spend driving? ____

Diet History

List your typical breakfast: ____
____
List your typical lunch: ____
____
List your typical dinner: ____
____
List any snacks: ____

How much coffee do you drink: _______________ Tea? _______________ Soda? _________________________
How much water? __________________ Diet beverages (list kind)? ______________________________________

Are you/have you been on any specialized diet (s)? Why?____
____
____

Please use the space below to elaborate on your issue or give any information which might have been missed in the previous questionnaires:
____
____
____
____
____