Mosenthal
Spine & Sport

www.MosenthalSpineandSport.com

Health History Form

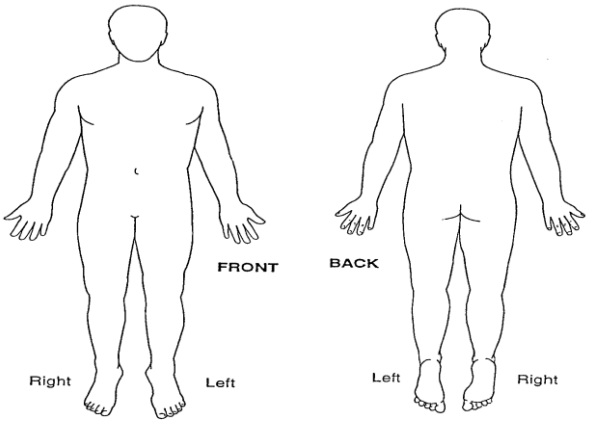
Name: _____ **Date of Birth**:____/____/___ **Today's Date**:____/____/____

1. Occupation: _____ Employer: _____
2. The symptom(s) that have prompted me to seek care today include:_____

   _____
3. Have you consulted a chiropractor before? ☐ Yes ☐ No If yes, 'Activator Chiropractic? ☐ Yes ☐ No
4. **Onset:** When did you first notice your current symptoms?_____
5. What event/situation do you feel caused your symptom? _____
6. Are your symptoms due to an auto or work-related injury? (circle) Yes No
7. **Intensity:** How extreme are your current symptoms? ***0*** ☐☐☐☐☐☐☐☐☐☐ ***10***
   Absent Uncomfortable Agonizing
8. **Duration and Timing:** When did it start and how often do you feel it?
   a. ☐ Constant ☐ Comes & Goes, How often:_____
9. **Quality of Symptoms:** What does it feel like?

☐ Numbness	☐ Aching	☐ Burning	☐ Other:_____
☐ Tingling	☐ Cramps	☐ Shooting	_____
☐ Stiffness	☐ Nagging	☐ Throbbing	_____
☐ Dull	☐ Sharp	☐ Stabbing	

10. **Location** of Symptoms: (Circle) Include **R**=right or **L**=left Jaw___; Headache___; Neck___; Shoulder___; Elbow___; Wrist___; Mid-Back___; Low-Back___; 'Sciatica'___; Hip___; Knee___; Ankle___
11. **Location:** Draw location of hurt? ***("O" for current condition, "X" for conditions experienced in past)***



12. **Radiation:** Does it affect other areas of your body? To what areas does the pain radiate?

    _____
13. **Aggravating or Relieving Factors:** What makes it better or worse, such as time of day, movements, activities?

    Circle: Problem **worsens** with: Standing Walking Sitting Bending Sleeping Arching backwards AM PM

    Describe: _____

    Circle: Problem **lessens** with: Ice Heat Walking Sitting

    Describe what lessens the problem?_____

14. **Other Relieving factors:** What makes it better?

☐ Prescription drugs	☐ Surgery	☐ Ice
☐ Over the counter drugs	☐ Acupuncture	☐ Heat
☐ Homeopathic remedies	☐ Chiropractor	☐ Other:_____
☐ Physical Therapy	☐ Massage	_____

15. **Activities:** How does your current condition interfere with your life and ability to function?

	No Effect	*Mild Effect*	*Moderate Effect*	*Severe Effect*		*No Effect*	*Mild Effect*	*Moderate Effect*	*Severe Effect*
Sitting	☐	☐	☐	☐	Grocery shopping	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐	Household chores	☐	☐	☐	☐
Standing	☐	☐	☐	☐	Lifting objects	☐	☐	☐	☐
Walking	☐	☐	☐	☐	Reaching overhead	☐	☐	☐	☐
Lying down	☐	☐	☐	☐	Showering/Bathing	☐	☐	☐	☐
Bending over	☐	☐	☐	☐	Dressing myself	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐	Love life	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐	Getting to sleep	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐	Staying asleep	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐	Concentrating	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐	Exercising	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐	Yard Work	☐	☐	☐	☐

16. Recent Fever / Infection? Yes No Unexplained Weight Loss? Yes No

Muscle Weakness? Yes No Pain with unration or bowel movements? Yes No

17. Any recent changes in your life that you think is contributing to today's symptom? (circle)

Increased Stress Increased Computer Work New Diet Change in exercise/activity Medication Surgery

18. Do you feel that today's symptom is due to: (circle) Muscle strain Nerve pinch Disc Old mattress

Stress Repetitive strain Poor posture Too much sitting Recent cold/virus Menstruation

Urinary tract infection Trauma / Injury Diet Telephone use Other: _____

19. How are your symptoms changing: (circle) Getting worse Staying the Same Getting Better

20. What else should we know about your current condition: _____

_____

21. Is this the first occurrence of this symptom for you? (circle) Yes No

22. Since your symptoms started, who have you seen for evaluation / treatment:

PCP PT/OT DC Massage Therapist Orthopedist No One/Self Treat Other: _____

23. Describe any recent diagnosis from your PCP: _____

24. For today's symptoms, have you had an (circle) X-Ray MRI Bloodwork Other: _____

25. **Work Environment:** (circle) Sit Stand Desktop computer Laptop

Do you use a sit/stand work station? (circle) Yes No Frequent telephone use ? (circle) Yes No

If you sit for your work, recent ergonomic assessment? (circle) Yes No

26. **Medical History:** Please mark any of the following that you have or have had in the past

☐ Acid Reflux/GERD	☐ Cancer	☐ Headaches	☐ Kidney Disease
☐ ADHD	☐ Chronic Cough	☐ Hearing Loss	☐ Liver Disease
☐ Alcoholism	☐ Chronic Pain	☐ Heart Disease	☐ Osteoporosis
☐ Anemia	☐ COPD/Emphysema	☐ Heart Palpitations	☐ Seizure Disorder
☐ Anxiety	☐ Dementia	☐ Hepatitis	☐ Sexually Transmitted Disease
☐ Arthritis	☐ Depression	☐ High Blood Pressure	☐ Stroke
☐ Asthma	☐ Diabetes	☐ High Cholesterol	☐ Thyroid Disease
☐ Bleeding Disorders	☐ Eating Disorder	☐ HIV/AIDS	☐ Tuberculosis
☐ Bowel Problems	☐ Glaucoma/Cataracts	☐ Immune disorders	☐ Other:_____

27. **Current Medications**: Include Herbals and Supplements

Name of Medication	**Strength** (ex. 500 mg)	**Dosing Instructions** (ex. Twice a day)

28. **Operations:** Please list any surgical interventions/operations

Type of Operation	**Date**	**Type of Operation**	**Date**

29. **Treatments:** Check the one's that you have received in the past or currently receiving

Past	***Current***		***Past***	***Current***		***Past***	***Current***	
☐	☐	Acupuncture	☐	☐	Dialysis	☐	☐	Hormone Replacement
☐	☐	Antibiotics	☐	☐	Dry Needling	☐	☐	Ice
☐	☐	Birth Control Pills	☐	☐	Exercise Program	☐	☐	Inhaler
☐	☐	Blood Transfusions	☐	☐	Heat	☐	☐	Massage Therapy
☐	☐	Chemotherapy	☐	☐	Herbs	☐	☐	Physical Therapy
☐	☐	Chiropractic Care	☐	☐	Homeopathy	☐	☐	Nutrition Supplements

30. **Family History:** Please tell us about the health of your immediate family

	Father	Mother	Siblings	Children	Other
Age at Death					
Cause of Death					
Heart Disease/ Stroke					
High Blood Pressure					
Diabetes					
Cancer (type)					
Epilepsy/Seizures					
Asthma					
Blood Disease					
Other:					

31. **Social History:** Tell us about your **health habits**

Marital Status	Single Significant Other Married Divorced Widowed	
Living Situation	Alone Spouse/Significant other Children/Family Other	
Are you pregnant?	Yes / No Hysterectomy Menopause Tubal ligation	
If Pregnant,	When is your due date?	
Do you have children?	Yes / No	If yes, how many?
Education (highest level)	9 10 11 12 GED Some college Associates Bachelors Masters PhD	
Are you working?	Yes / No	If yes, occupation?
Are you disabled?	Yes / No	If yes, reason?
Legal actions related to symptom?	Yes / No	Explain:

			If applicable, amount?
Tobacco Use?	Yes / No	Cigarettes / Cigars / Chew	Per day:
If no, have you ever?	Yes / No	Cigarettes / Cigars / Chew	Per day: How Many Years:
Do you drink alcohol?	Yes / No	Beer / Wine / Liquor	Per day:
Do you drink caffeine?	Yes / No	Coffee / Tea / Soda / Energy Drink	Per day:
Any present illicit drug use?	Yes / No	Marijuana / Cocaine / Heroin / Illicit Rx. / Other	
Any past illicit drug use?	Yes / No	Marijuana / Cocaine / Heroin / Illicit Rx. / Other	
Do you exercise?	Yes / No	Type?	Per week:
Do you wear your seatbelt?	Yes / No	If yes, percent of time:	
Mattress & Pillow: Age and Type			
Hours of sleep per night?			
Preferred sleeping position		Back Side Stomach	
Use a supportive neck pillow ?	Yes / No		
Wear shoes with good support?	Yes / No		
Wear a heel lift	Yes / No	If yes, (circle) Right or Left	
Do you carry a heavy purse?	Yes / No		
Rate your current daily posture:		Excellent Good Average Poor	
Satisfied with your weight ?	Yes / No		
Rate your diet:		Excellent Good Average Poor	
Rate your stress level		(minimal) 1 2 3 4 5 6 7 8 9 10 (severe)	
Daily meditate / pray / truly relax?	Yes / No	5-10 min	

32. Any other information you think we should know regarding your current symptom: Please describe.

_____

Signature: _____ Date: _____ / _____ / _____