PATIENT'S HISTORY FORM

Please Print **(use only black ink)**

Complaint #____How would describe your chief complaint at this time?

____

____

When did it start? Date ____

(include at least the moth and year, day if known)

What is your history with this injury? [ ] Sudden Trauma [ ] Reoccurrence [ ] Repetitive Trauma

What makes the pain worse?

____

What make the pain better?

____

Where is the pain located?

____

At what time of day or week is the pain worse?

____

The pain is…….

[ ] Intermittent [ ] It usually last for __ [ ] minute(s) [ ] hours [ ] day(s) [ ] week(s)

[ ] Constant

How long have you been having pain?	How many times have you had this problem?	When did you first have these or similar symptoms?
[ ] 1 week or less	[ ] Never	[ ] Never
[ ] 1-6 weeks	[ ] 1-3 episodes	[ ] Less than 6 months ago
[ ] >6 weeks but less than 3 months	[ ] 4 or more episodes	[ ] 6 months to 1 year
[ ] 3 month to 1 year		[ ] More than 1 year ago
[ ] Over 1 year		

Yes **Motor Vehicle Accident**	Yes **Job Injury**	Yes **Personal Injury**
[ ] Is your pain the result of a motor vehicle accident?	[ ] Is your pain the result of a work related injury?	[ ] Is your pain the result of a personal injury outside of work or a motor Vehicle accident?

Location of impact

- [ ] Rear end
- [ ] Frontal
- [ ] Side
- [ ] Both Front & Rear
- [ ] Both Front & Side
- [ ] Both Side and Rear

Have you been disabled from working because of the pain during the year? ……………… [ ] Yes [ ] No

Have you filed a workman's compensation claim?.. .[ ] Yes [ ] No

Have you filed a legal suit?...................................... [ ] Yes [ ] No

Disabled from ______________________________ to ____

I authorize Kenneth A. Felt, DC to release any information necessary to expedite insurance claims on my behalf. I understand that I am responsible for charges that are not covered by my insurance plan.

RELEASE OF INFORMATION: I authorize the physician examining and or treating me to release to any third party any Medical information and records concerning diagnosis and treatment when requested.

Signature of Patient or Guardian ____ Date: ________________