


# General History Worksheet

Name: _____		Age: _____		Date: _____	
What brings you here today? _____					
Location: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both sides					
Injured at work? Y N    Auto Accident? Y N    ***Please provide auto/work comp info***					
Date of injury or first symptoms: _____					
How did it happen? _____					
<b>History:</b> <div style="text-align: center; margin: 10px 0;">           Pain Scale   </div> Mark typical pain level _____ What makes it worse? _____ What makes it better? _____					
Previous Injury / Treatment: _____					
Other symptoms besides pain: _____					
<b>MEDICAL HISTORY</b> (check all that apply)					
<b>Family History:</b> Blood clots <input type="checkbox"/> Cancer <input type="checkbox"/> Bone problems <input type="checkbox"/> Arthritis <input type="checkbox"/> type: _____			<b>Personal History:</b> Diabetes <input type="checkbox"/> Blood clots <input type="checkbox"/> Acid reflux <input type="checkbox"/> Gout <input type="checkbox"/> Bone problems <input type="checkbox"/> Arthritis <input type="checkbox"/> Cancer <input type="checkbox"/> Other: _____		
<b>Do you currently have any of the following?</b> (check all that apply--may not relate to above problem)					
Fatigue <input type="checkbox"/>	Anxiety <input type="checkbox"/>	Wheezing <input type="checkbox"/>	Blurred vision <input type="checkbox"/>		
Weight loss <input type="checkbox"/>	Stomach pain <input type="checkbox"/>	Breathing difficulties <input type="checkbox"/>	vision problems <input type="checkbox"/>		
Fever or chills <input type="checkbox"/>	Stomach ulcers <input type="checkbox"/>	Cough <input type="checkbox"/>	<b>Females only:</b>		
Dizziness <input type="checkbox"/>	Black stools <input type="checkbox"/>	Hoarseness <input type="checkbox"/>	Regular Periods <input type="checkbox"/>		
Racing Heart <input type="checkbox"/>	Numbness <input type="checkbox"/>	Allergies <input type="checkbox"/>	Eating disorders or		
Chest pain <input type="checkbox"/>	Tingling <input type="checkbox"/>	Rash <input type="checkbox"/>	problems <input type="checkbox"/>		
Depression <input type="checkbox"/>	Weakness <input type="checkbox"/>	Itching <input type="checkbox"/>			
Previous surgeries? Y N					
Current medications: (list name) _____					
Allergies to medicines? Y _____ None <input type="checkbox"/>					
<b>Adults:</b> Occupation? _____ Married? Y N    Kids? _____ Do you smoke? Y N			<b>Kids:</b> Where do you go to school? _____ Hobbies? _____		