GENERAL HEALTH HISTORY QUESTIONNAIRE

PATIENT INFORMATION:			
Name		Date	
Height	Weight	DOB	Age

What is your MAJOR symptom/problem?	YEAR SYMPTOM BEGAN
1.	

ACCIDENT INFORMATION:

Is your condition due to an accident? □No □Yes Date:_____ Type of accident? □ Automobile □ Work □ Home □ Other_____(explain)

MEDICATIONS: (All PAIN medication)	DOSAGE & FREQUENCY	RESPONSE (none, short term, helps)

PATIENT CONDITION

1. Have you had this problem before? □ Yes □ No
2. Is your condition getting progressively worse? □ Yes □ No
3. Is the problem: □ Constant □Comes and goes □ **worse in am** □ **worse in pm** □stiffness in: **am** or **pm**
4. How does it feel? □ Burning □ Sharp □ Shooting □ Dull □Aching □ Stiff □ Tingling □ Throbbing □Swelling □Cutting □Knifelike □ Excruciating □Numbness □ Pins and needles □ Bone pain □Pressure □ Stabbing □ Tight band □Sore □Bruised □Other
5. **Joint noises?** □clicking □grinding □popping □locking □swelling?
6. **Headaches?** Yes or No. **Frequency?** □1-2 per week, □3-4 per week, □more? **Duration?** □4-6 hours □Days

Circle below the severity of your current pain on a scale of 0-10

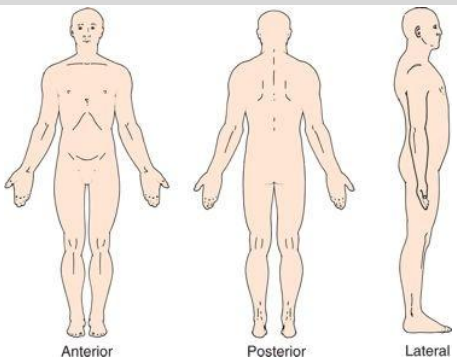
(No pain) **0 1 2 3 4 5 6 7 8 9 10 (severe pain)**

Circle below the *maximum severity* of pain experienced on a scale of 0-10

(No pain) **0 1 2 3 4 5 6 7 8 9 10 (severe pain)**

1. What makes your condition better? _____
2. What makes your condition worse? _____
3. **Does it interfere with your** □ Work □ Sleep □Daily Routine □Recreation □ Sports □Hobbies □ Other
4. **What activities/movements are painful to perform:** □Sitting □Standing □Walking □Bending □ Lying down □Getting up □ Turning neck/trunk □When still or moving □Kneeling/squatting □Driving □Lifting
5. **What treatment or therapies have you tried?** □ Physical therapy □ Chiropractor □Acupuncture □Pain injections □Massage□ Other_____ **Did it help?** Y/N □**Short term**

PLACE A MARK WHERE IT HURTS



Patient Name_____ **DOB**_____

PAST HEALTH HISTORY

Have you been diagnosed with □ Cancer □ High Blood Pressure □ Diabetes □Kidney disorder□ Liver disorder
Any Surgeries related to current issue? □Yes □ No Type:_____ What year: _____
Any major accidents?□ Y □N What year: _____
Any fractures? ?□ Y □N What location_____ What year: _____
Have you had any imaging □ X-rays □ MRI □ CT □ Ultra Sound □ LABs Results: □ **Normal** or□ **Abnormal**
Last blood work? _____ □ **Normal** or□ **Abnormal**
Any Allergies to medication? □ Y □N What medication? _____
Any seizure history? □ Y □N
Are you currently taking anticoagulants such as Aspirin, Warfarin or Coumadin? □ Y □N

SOCIAL HEALTH HISTORY

Do you smoke cigarettes? □ Y □N #per day _____ **Former Smoker?** □
Do you drink alcohol? □ Y □N □ **occasionally**
Are you currently working? □ Y □N Occupation? _____
Do your job duties include □ desk job □ standing □ lifting □stooping□ kneeling □ twisting of body□ turning of neck □ bending neck.
Do job duties involve, lifting up to____lbs x ___per week
How many hours a night do you sleep? _____ **Does your pain interfere with your sleep?**□Yes □No
Energy level:(Please circle) 0 1 2 3 4 5 6 7 8 9 10 **(10/10 is feeling best)**
Cannabis Experience: □New □Moderate □Experienced
If this a renewal has MMJ: □Improved quality of life □Decreased pain □Improved sleep □Improved mood
Since last visit is your pain? □About the same □A little: **better** or **worse** □A lot: **better** or **worse**

ORGAN SYSTEM REVIEW- DO YOU HAVE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

General: □Chills □Fever □Weight loss □Night sweats □ Night pain □AM stiffness □Rashes □Puffy □Poor appetite

Head: □ Ear ringing □Headaches □ Blurry vision □ Glaucoma □Nasal fractures □Tooth pain □Jaw pain □Vertigo □Tongue pain □Macular degeneration □Facial paralysis □Vision loss

Musculoskeletal: □Neck pain □Back pain □Weakness □Muscle/joint pain or stiffness □Paralysis □Limitation of movement □ Arthritis □Fibromyalgia □ Muscle atrophy □ Muscle spasms □ Pain bending □Pain lifting

Cardio: □ Chest pain □Murmurs □ Cardiac disorder □High Blood Pressure □Angina □Abnormal EKG □Congestive Heart Failure □Heart Attack □Kidney Disorder □Arrhythmia □Pacemaker/defibrillator

Lungs: □Shortness of breath □Asthma □COPD □Emphysema □ Lung Cancer □ Respiratory disorder

Abdomen: □ Crohn's disease □ Hepatitis C □ Nausea □ Vomiting □ Decreased appetite □Constipation □Diarrhea □Rectal Bleeding □Bowel dysfunction □ Bladder dysfunction BM's per/day___
Any pain with urination? □ Y □N □Heartburn □Ulcers □Hemorrhoids Bleeding? □ **Y** □**N**

Male: □ Prostate cancer □ Testicular cancer □Low sex drive □ Weight gain □Sexual dysfunction □ Fatigue □Problems reaching climax □Urinary urgency/frequency □Enlarged prostate

Female: □PMS □Heavy Bleeding □Pelvic pain □Vaginal discharge □Low sex drive □Fatigue □Insomnia □Urinary incontinence □ Fibroids □Uterine/cervical cancer □Severe menstrual cramps □Heavy periods □Abnormal breast exam □Endometriosis □Pain with intercoure □Abnormal pap □Gynecolgoical surgery
Date of last menstrual cycle: _____ **Are you pregnant?** □ **Y** □**N**

Breast: □ Cancer □ Prior surgery/biopsy Last mammogram_____
□Chemo □Radiation □Nausea □Weight loss □ Breast pain □Breast implants

Neuro: □MS □Epilepsy □ ALS □ Alzheimer's □ Fainting □Dizziness □ Numbness □ Tingling/burning □Tremors □Stroke □ Seizures □ Headaches □Motor/verbal tics

Heme-Lymph: □Lymph node enlargement or tenderness □Ankle swelling, □Bleeding disorder □Cancer

Psych: □PTSD □Anxiety □Depression □Panic Attacks □Bipolar □Schizophrenia □ASD □ADD/ADHD □Insomnia □Personality DO