



Health History

Date: _____

Name: _____

Occupation: _____ Years: _____

Marital Status: Single Married Divorced Widowed

Chief Complaint:

Where is the pain? Neck Mid-Back Lower Other

Date it started: _____ Where were you? _____

Was it gradual or instant pain? _____

What caused it? _____

Is it getting better or worse? _____

Rate your pain where 1 is annoying and 10 is unbearable: _____

How often do you experience this pain (0 to 100%): _____

What relieves the symptoms? _____

What makes them worse? _____

Is it worse with rest or activity? _____ Time of day most frequent: _____

Are there any positions that make it worse? _____

Are there any radiations or extremity pains? _____

Other or New Symptoms:

Where is the pain? Neck Mid-Back Lower Other

Date it started: _____ Where were you? _____

Is it getting better or worse? _____

How is it affecting your daily life? _____

Current or Past: Broken Bones Surgeries Trauma Illness Allergies

Please explain: _____