417 Geyser Road
Ballston Spa, NY 12020
538 Maple Ave
Saratoga Springs, NY 12866
(518) 587-3256 fax: 587-5210

Patient Health History

Name: ______________________ Date of Birth: ______________________

History of Present Condition

Current Complaints:______________________

When did your symptoms start (date)?:______________________

If you are coming in due to an injury, how did you injure yourself?:______________________

If you are coming in after surgery please explain:______________________

Surgery Date:______________________

List diagnostic tests for this problem (include x-rays, MRI, EMG, etc.): ☐ Check if no previous diagnostic testing

TEST	DATE	RESULT

Pain:

Please describe your pain (e.g., burning, stabbing, ache):______________________

Where is your pain located?_):______________________

When is the pain at it's worst?: ☐ Morning ☐ Night ☐ With activity ☐ At rest

Is the pain?: Constant ☐ On and off

Please fill in the appropriate number for each of the below times: *Rating: 0 ------------------------ 5 ------------------------ 10*

Now?:___________ At its best?:__________ At its worst?:_________ *No Pain* *Moderate* *Hospital*

Are your symptoms getting…? ☐ Better ☐ Worse ☐ Staying the same

What makes your symptoms worse?______________________

What makes your symptoms better?______________________

What activities do you have difficulty doing?_______ What previous activities do you want to resume?__

Are you out of work because of this problem?: Yes ☐ No ☐

When do you intend to return to work (date)?:______________________

What treatment have you receive for this present condition (surgery, injections, chiropractor, splint or brace, medication, etc.)?:

Are you planning to follow-up with the referring physician?: ☐ Yes ☐ No If so, When?:_________________

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Patient Health History (continued)

Past Medical History

Please check if you have any of the following:

______ Allergies ______ COPD High Blood Pressure Multiple Sclerosis Visual Loss

______ Anemia ______ CVA (Stroke) HIV/AIDS Parkinson's Other _________

______ Arthritis ______ Diabetes Hypoglycemia Polio Other _________

______ Bone Loss ______ Gout Kidney Disease Seizure Disorder Other _________

______ Cancer _______ Hearing Loss Liver Disease Thyroid

______ Cardiac (MI, Arrhythmia, Angina) Lupus Vascular Disease

Past Surgeries:

TYPE	DATE
1.	
2.	
3.	
4.	

Have you ever broken any bones?:______________________________

Past motor vehicle accidents?:______________________________

Please list any medications you are taking:______________________________

Please note any known allergies to medications:______________________________

Do you wear a pacemaker?:______________________________

Do you have any metal implants?:______________________________

Are you or do you think you may be pregnant?: ☐ Yes ☐ No

Do you smoke? Yes ☐ No ☐ How long have you smoked?:______________________________

Are you working? Full ☐ Part-Time ☐ Retired ☐ Student ☐ Not Employed ☐

Occupation:______________________________