CROSS
SPINE & DISC
NON-SURGICAL SOLUTIONS

PATIENT HISTORY

Name: ____ Date: ____________________

Present Medical History:

What can we help you with? ____

____

How long have you had this problem? ____
Have you had any previous care or seen any other provider(s) for this problem? ____________________
____

What are you doing for it now? ____
Is it working? ____

Have you noticed any changes in your daily activities due to the problem or pain (i.e. dressing, cooking, etc)? ____

Are there any other related or unrelated symptoms? ________________________________
____

What is your overall stress level?
LOW 0 1 2 3 4 5 6 7 8 9 10 HIGH

What is your sleeping habit? On BACK On SIDE On STOMACH

When was the last time you really felt good? ___________________________________

FAMILY HISTORY:

Mother:	Living	Health Problems: ____________________________
	Deceased	Age: __________
Father:	Living	Health Problems: ____________________________
	Deceased	Age: __________

PAST MEDICAL HISTORY:
Medications Currently Taking: ____
Supplements: ____
Other physicians being seen for any reason (including pregnancy) ______________________

Have you ever had any serious falls, accidents, strains, hospitalizations, surgeries, lengthy illnesses? YES NO
If yes, please describe: ____
____

Patient Signature: ________________________________ Date: ______________