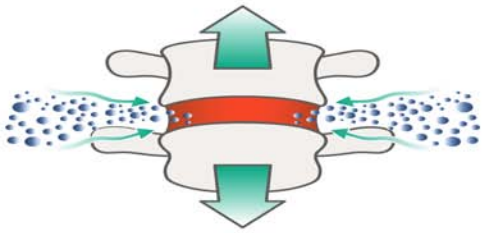

CROSS
SPINE & DISC
NON-SURGICAL SOLUTIONS

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: _____