TRI-STATE NEUROSCIENCE CENTER, INC.

PATIENT HEALTH HISTORY

Name_______________________________________Male/Female

Age_______Weight_______Height_______Are you right or left handed?_______________

Are your symptoms a result of the following:

☐ Work Related Date:____________ Are you currently working? ☐Yes ☐ No

☐ Auto Accident Date:____________ If no, last day worked_______________

☐ Other Liability Date:____________

Describe your symptoms:____

____

Date of onset of symptoms: ______________

PRIOR TREATMENT:

Physical Therapy ☐ Yes ☐ No

Chiropractor ☐ Yes ☐ No

Oral Steroids ☐ Yes ☐ No

Epidural Injections ☐ Yes ☐ No

Non-Steroidals/Anti-Inflammatories ☐ Yes ☐ No

Pain Medications ☐ Yes ☐ No

PAST MEDICAL HISTORY:

☐ Hypertension	☐ Stroke	☐ Arthritis
☐ Diabetes	☐ Cancer	☐ Drug Abuse
☐ Heart Problems	☐ Stomach Problems	☐ Psychiatric
☐ Lung Problems	☐ Kidney Problems	☐ Thyroid Disorder

List all surgeries and when they were performed:

Surgery	Date

List all medicines you are taking and dosages, including birth control pills and vitamins:

Medicine	Dosage

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list:____

Have you ever had:

☐ CT Scan Date:___________ ☐ EMG Date:___________

☐ MRI Date:___________ ☐ EEG Date:___________

☐ Myelogram Date:___________ ☐ X-rays Date:___________

☐ Other Date:___________

Habits:

Do you smoke? ☐ Yes ☐ No - If yes, how much?_______________

Do you drink alcohol? ☐ Yes ☐ No

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

FAMILY HISTORY:

☐ Back Pain ☐ Aneurysm

☐ Neck Pain ☐ Stroke

☐ Brain Tumor

Were you referred by another physician? ☐ Yes ☐ No

If yes: Name_____________________________Address______________________________

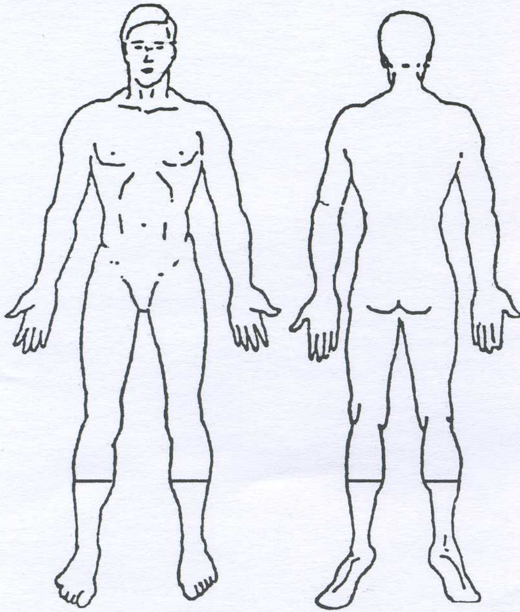
Family physician(if different than above)

Name__________________________________Address______________________________

Other physician you would like to receive a report of findings:

Name__________________________________Address______________________________

Please Shade the location of your pain



BP: ______________________________

Carotids: ______________________________

Comments: ______________________________

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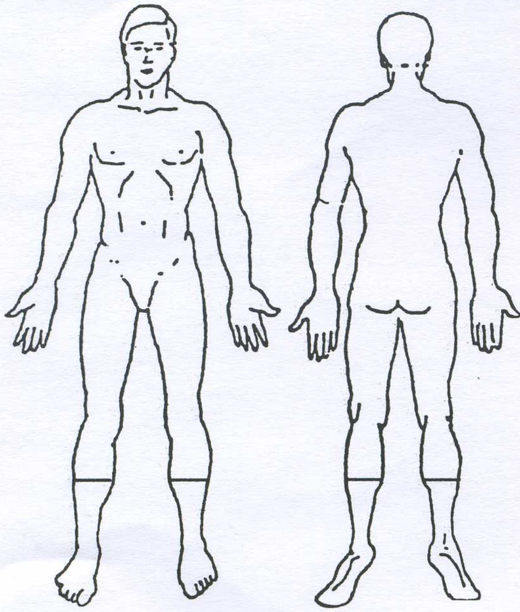
Have you experienced any weakness in your affected areas? ______________________________

Do you experience any tingling and numbness? If so, where? ______________________________

Please Shade the location of your numbness/tingling (i.e. pins and needles)



Patient Signature ______________________________ **Date** ______________

Physician Signature ______________________________ **Date** ______________