Rosemary Heights Clinic

<u>Patient History Form</u> **Name:____________________________** **File#:____________**

Why are you seeking treatment? ____
How long have you had this problem? ____
Is the pain/discomfort constant? ____Yes ____No
Please describe your symptoms: ____

____
What aggravates your pain/discomfort?____
What relieves your pain/discomfort? ____
Does the pain radiate/travel anywhere else in your body? ___Yes ___No
If you answered yes to the above question, where does the pain radiate? _____________________
On a scale of 0 to 10 (0= no pain, 10= worst pain) please rate your pain/discomfort today: ____/10
Have you seen anybody else for this problem: ___Yes ___No
If you answered yes to the above, please indicate who you saw (MD, massage therapist, physiotherapist, etc)________________ and the results _____good ______poor _____no change

<u>General Health Questions</u>

Please CIRCLE the answer closest to how you currently feel: (1=poor, 5=excellent)

Quality of Sleep	1 2 3 4 5
Energy Level	1 2 3 4 5
Eating Habits	1 2 3 4 5
Stress Levels	1 2 3 4 5
Exercise Habits	1 2 3 4 5

Smoker:__Yes__No__Occasional
Alcohol:__Yes__No__Occasional

Please indicate any other information about your health history that you believe would be important for the doctor to know (ie: previous injuries, hospitalizations, medications, stress levels)

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