MANCHESTER-BEDFORD MYOSKELETAL LLC
Patient Health History

Date: ____________________

Name: ____ *Date of Birth:* ____________
first *mi* *last*

Address: ____

City: ______________________________ *State:* __________ *Zip:* __________________

Phone: ____________________ ____________________ ____________________
Home *Mobile* *Work*

Email Address: ______________________________ *Occupation:* ______________________________

In Case of Emergency: _________________________ *Phone:* ______________________________

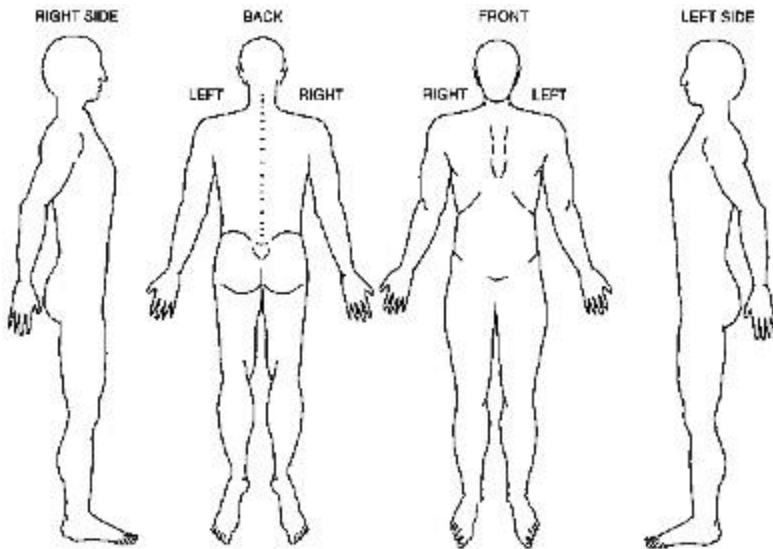
Primary Care Physician: ____
Name *Address* *Phone*

Referred By: ____
Physician, person, or media

If currently under a physician's care other than your primary, state doctor's name, clinic & phone:

____

Please place letters from legend below as closely as possible to spots on diagram where you experience pain, injury, tension, stiffness or restriction of movement.



M=Mild	O=Mod	E=Severe
D=Dull	S=Sharp	B=Stabbing
H=Hot	P=Pulsating	A=Aching
G=Shooting	T=Tingling	R=Throbbing

If pain travels, place an 'X' where it starts and draw an arrow to where it travels

Please indicate location of any known scars by drawing a lightning bolt at the location

Place a check any of the following you have had or are now having problems with:

☐ Anemia	☐ Athlete's Foot	☐ Bowel/Bladder Problem	☐ Bronchitis	☐ Bursitis	☐ Carpal Tunnel Syndrome
☐ Chest Pain	☐ Constipation	☐ Coronary Heart Disease	☐ Diabetes	☐ Dizziness/ Vertigo	☐ Fibromyalgia
☐ Flat/High Arches	☐ Flat Back	☐ Fwd. Head Posture	☐ Headache	☐ Heart Condition	☐ Hernia
☐ Hepatitis	☐ Herpes	☐ High/Low Blood Pressure	☐ Hip Pain/ Surgery	☐ Immune deficiency	☐ Jaw/TMJD
☐ Knee/Hip Replacement	☐ Migraine	☐ Nervousness	☐ Osteoarthritis	☐ Pacemaker	☐ Palpitations
☐ Phlebitis	☐ Plantar Fasciitis	☐ Poor Circulation	☐ Pregnant/Childbirth	☐ Range of Motion Limited	☐ Rh Arthritis
☐ Rib Dysfunction	☐ Rotator Cuff Disorder	☐ Rounded Shoulders	☐ Sacroiliac Joint Dysfunction	☐ Seizure/ Convulsion	☐ Sciatica/Piriformis Syndrome

Acute pain/injuries: ____

Chronic pain/injuries: ____

Recent surgeries (past 2 yrs): ____

Older surgeries: ____

Bone breaks, fractures (past 5 yrs): ____

Severe muscle strain/sprain (past 5 yrs): ____

Other medical conditions: ____

Allergies: ____

Current medications (including naturopathic): ____

Do you wear eyeglasses or contacts? ☐ *Yes* ☐ *No* ☐ *Reading*

Regular exercise? (Per week frequency): ☐ *None* ☐ *1-2* ☐ *3-5* ☐ *More*

Current reason for visit: ____

____

Workplace Injury? ☐ *Yes* ☐ *No* ☐ *Worker's Comp*

If current problem resulted from a motor vehicle accident, please diagram below:

Please read carefully, print this document, and sign below.

I attest that the information I have provided is true and complete to the best of my knowledge. I understand that the information provided by me on this form is confidential and will not be released without my written consent.

Print Name: ______________________________ Signature ______________________________