Manchester-Bedford Myoskeletal LLC
VA Patient Health History

Service: ☐ Army ☐ Marine Corps ☐ Navy ☐ Air Force ☐ Coast Guard ☐ Merchant Marine *Date:* ________________________

Name: ____ *SSN:* _________________________
first *mi* *last*

Address: ____ *DOB:* _________________________
street *apt, unit*

City: ____ *State:* ________ *Zip:* ________________ *Sex:* ☐ M ☐ F

Best Contact Phone: (______) _____-________ *Best Contact Email:* ____

Alternate Phone: (______) _____-________ *Alternate Email:* ____

Emergency Contact: ______________________________ *Relationship:* _______________________ *Phone:* (______) _____-_______
name

Primary Care Physician: ____
name *address* *phone*

Referring Physician: ____
name *facility/clinic/hospital* *phone*

Primary Complaint: ____

Secondary Complaints: ____

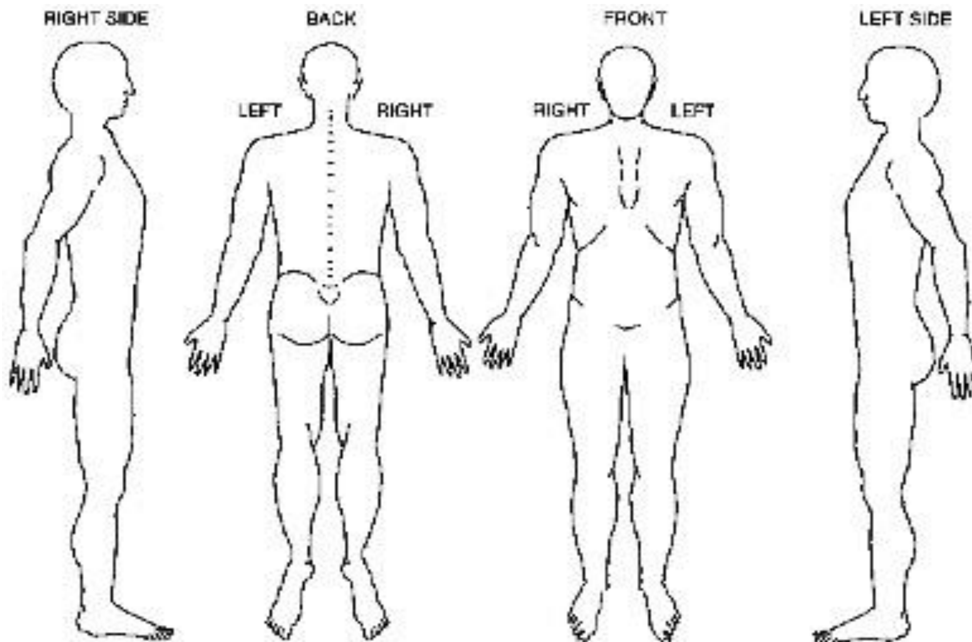
____

Recent Diagnoses: ____

Circle daily maximum & average pain level (where 0=no pain, 10=most pain)

0 1 2 3 4 5 6 7 8 9 10

Please indicate on diagram as closely as possible where you experience pain, injury, tension, stiffness or restricted movement.



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

Please indicate location of surgical scars by drawing a zigzag line (ϟ) at the location

Please check any of the following problems/conditions you have had or are currently experiencing:

☐ Anemia	☐ Dizzy/Vertigo	☐ Herpes	☐ Neuropathy	☐ Rib Pain
☐ Ankle Dysfunction	☐ Edema/Joint Swelling	☐ Hip Pain	☐ Orthopedic pins/plates	☐ Rotator Cuff
☐ Athlete's Foot	☐ Fibromyalgia	☐ HIV	☐ Osteoarthritis	☐ Sciatica/Piriformis
☐ Back Pain	☐ Flat Back	☐ Hypertension	☐ Osteopenia/-porosis	☐ Seizure
☐ Balance/Vestibular	☐ Flat Neck	☐ Immune Disorder	☐ Pacemaker	☐ Shoulder Problem
☐ Bowel/Bladder	☐ Flat/High Arches	☐ Jaw/TMJD	☐ Palpitations	☐ SI Joint Dysfunction
☐ Bronchitis	☐ Fwd Head Posture	☐ Joint Replacement	☐ Pelvis/Pelvic Floor	☐ Spinal Stenosis
☐ Bursitis	☐ Groin Dysfunction	☐ Knee Dysfunction	☐ Phlebitis	☐ Spinal Surgery
☐ Carpal Tunnel	☐ Headache	☐ Legs Turned In/Out	☐ Plantar Fasciitis	☐ Spine Pain/Dysfunction
☐ Chest Pain	☐ Heart Condition	☐ Migraine	☐ Pregnant	☐ Stress/Anxiety/Panic
☐ Circulatory	☐ Heart Disease	☐ Mil Sexual Trauma	☐ PTSD	☐ Thoracic Pain
☐ Constipation	☐ Hepatitis	☐ Neck Pain	☐ Range of Motion Limit	☐ Traumatic Brain Injury
☐ Diabetes	☐ Hernia	☐ Nervousness	☐ Rh Arthritis	☐ Whiplash

Acute pain/injuries: ____

Chronic pain/injuries: ____

*Recent surgeries (mo/yr)(past 2 yrs):*____

*Older surgeries (yr):*____

Bone breaks, fractures (past 5 yrs): ____

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

Other medical conditions: ____

Allergies: ____

List all medications (including naturopathic): ____

Wear eyeglasses / contacts? ☐ *Yes* ☐ *No* ☐ *Reading* *Regular exercise? (per week):* ☐ *0* ☐ *1-2* ☐ *3-5* ☐ *More*

Treatment goals at this clinic: ____

____

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

If current problem resulted from a motor vehicle traffic 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 ______________________