LIFE STYLE HISTORY

Please complete this life style history so that I can help you to help yourself in the most complete way. I specialize in life improvement. I can help you to help yourself turn on the light which is life. Some of the questions are designed to get in touch with what is happening in your body physically as well as behaviorally.

Name_____ Social Security # _____

Address_____

City/State _____ ZIP _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Age _____ Birth date _____ Occupation _____

Marital Status: M S W D

#Children _____ Spouse's Name (if applicable) _____

Emergency Contact: Name _____ Phone_____

Referred By _____

PHYSICAL LIFE STYLE

Why did you decide to see me (i.e. Pain, Problem, Check-up)?

_____

_____

_____

_____

How long has this problem existed?

_____ 1 week or less _____ 1 to 6 weeks

_____ Greater than 6 weeks but less than 3 months

_____ 3 months to 1 year _____ Over 1 Year

List problem areas in order of severity (from most to least):

1. _____
2. _____
3. _____
4. _____

In general my symptoms are better in: ____AM ____Midday ____PM

In general my symptoms are worse in: ____AM ____Midday ____PM

____ Symptoms don't change with the time of day

Do you have night pain unrelated to movement? ____Yes ____No

Do you have constant pain unrelated to movement? ____ Yes ____No

Are your symptoms / condition: ____Improving ____Unchanged ____Getting worse

How has this condition changed your home or work life? _____

_____

What have you done to help yourself? _____

_____

Have you seen anyone for this condition? ____ Yes ____ No

If yes, Name _____

Location _____

Name _____

Location _____

List any medications you are currently taking, prescribed or over the counter:

1. _____ for _____

2. _____ for _____

3. _____ for _____

4. _____ for _____

What do you enjoy most in life (work, family, recreation)?

_____

Have you been in any Auto or Work related accidents? (If so, when?)

_____

_____

_____

Have you had any surgeries? (If so, when?)

_____

_____

Date of last physical exam? _____

Patient Signature _____
Parent or Guardian if Minor