Chicago Neuro

HEALTH HISTORY

Have you ever had any of the following medical conditions? Please circle yes or no. If yes, please explain.

			EXPLAIN IF YES
Allergies or hayfever	Yes	No	
Alcohol/drug abuse	Yes	No	
Anemia	Yes	No	
Arthritis	Yes	No	
Asthma	Yes	No	
Cardiac condition – heart murmur, congenital defect	Yes	No	
Cancer	Yes	No	
Chronic bronchitis or emphysema	Yes	No	
Chest pain or angina	Yes	No	
Depression or psychological concerns	Yes	No	
Diabetes	Yes	No	
Firbromyalgia or chronic pain syndrome	Yes	No	
Guillian - Barre Syndrome	Yes	No	
Gout	Yes	No	
Head injury or concussion	Yes	No	
Heart attack	Yes	No	
Heart surgery or pacemaker	Yes	No	
Hemophilia or other blood disorder	Yes	No	
High blood pressure or hypertension	Yes	No	
HIV positive or AIDS	Yes	No	
Hypoglycemia	Yes	No	
Kidney disease or stones	Yes	No	
Liver disease (Hepatitis, jaundice, cirrhosis)	Yes	No	
Migraine Headaches	Yes	No	
Multiple Sclerosis	Yes	No	
Parkinson's Disease	Yes	No	
Polio	Yes	No	
Pneumonia	Yes	No	
Rheumatic Fever or Scarlet Fever	Yes	No	
Seizure Disorder or Epilepsy	Yes	No	
Shortness of breath	Yes	No	
Stroke or TIA (transient ischemic attack)	Yes	No	
Thyroid problems	Yes	No	
Tuberculosis	Yes	No	
Ulcers or other stomach problems	Yes	No	
Other (please specify)	Yes	No	

WOMEN ONLY:
ARE YOU PREGNANT? ☐ YES ☐ NO IF YES, HOW FAR ALONG: _____
NURSING? ☐ YES ☐ NO

HEALTH HISTORY

Reason for this visit: (please circle) work, sports, auto, trauma, or chronic.
Please explain:

_____
_____

Please describe the pain and its location:

_____
_____

When did this condition begin: _____/_____/_____
Is this condition interfering with your (please circle): work, sleep, or daily routine.
If yes, please explain:

_____

Have you had this or similar conditions in the past: □ YES □ NO
If yes, please explain:

_____

Have you been seen elsewhere for this condition?

_____
_____

What x-rays, scans, CTs, or MRIs have you had recently: _____
Results:

_____

Goals for treatment:

_____
_____

Smoking Status: □ never smoked, □ current daily, □ current occasional, □ former smoker.
List all previous operations/hospitalizations:

_____
_____

List any past serious accidents with dates:

_____
_____

Are you wearing: □ heel lifts, □ sole lifts, □ inner soles, □ arch supports, □ orthotics
What age is your mattress? _____ Is it comfortable? □ Yes □ No
Have you had any illnesses in the last 3 weeks (cold, flu, urinary infection)? □ Yes □ No
Do you have a pacemaker, implant, or organ transplant? □ Yes □ No_____
Current occupation: _____

Does your job involve: □ prolonged sitting, □ prolonged standing,
□ prolonged walking, □ use of small equipment, □ use of large equipment,
□ frequent lifting, □ bending, □ climbing or turning, □ repetitive movement.

I understand the above information and guarantee this for was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes in my medical status.

_____ _____
Patient Signature Date

Chicago Neuro, 30 S Michigan Ave. Suite #302, Chicago, IL 60603