# Patient Health History

NeuroIntegrative Care Of Los Gatos

## PERSONAL INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Email _____ How did you hear about us? _____

*We will need to contact you both by phone & email. Please be sure to give us the best phone number to reach you*

Date of Birth _____ Cell Phone _____

Spouse's Name _____ Home Phone _____

Your Occupation _____ Retired? ☐ Yes ☐ No

## REVIEW OF SYMPTOMS

Please check ALL that apply. Use DIAGRAMS BELOW to designate locations.

### History of Chief Complaint

| | | | | |
|---|---|---|---|---|
| ☐ **Knee Pain** | ☐ **Shoulder Pain** | ☐ **Hand/Finger Pain** | ☐ Low Back Pain | ☐ Neck Pain |
| ☐ **Numbness** | ☐ **Fatigue** | ☐ **Limited Motion** | ☐ Pacemaker | ☐ Hi BP |
| ☐ **Herniated Disc** | ☐ **Bulging Disc** | ☐ **Spinal Stenosis** | ☐ Disc Degeneration | ☐ Sciatica |
| ☐ **Vascular Issues** | ☐ **Leg Pain** | ☐ Plantar Fasciitis | ☐ Anxiety | ☐ Depression |
| ☐ Chemotherapy | ☐ Arthritis in Feet | ☐ Shortness of Breath | ☐ Electrical Implant | ☐ Memory |
| ☐ Pinched Nerve | ☐ Joint Replacement | ☐ Poor Circulation | ☐ Spinal Surgery | ☐ Foot Operation |
| ☐ Cancer | ☐ Diabetes | ☐ **Neuropathy** | ☐ Other: | |

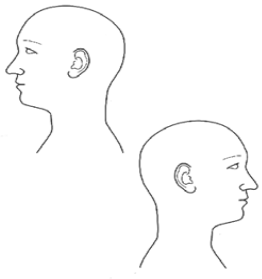
## PRESENT HEALTH CONDITION

**List the physical issues you are most interested in correcting.**

| | | LIST PAIN LEVELS 0-10 | LENGTH OF TIME: |
|---|---|---|---|
| 1. | | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 | _____ MON/YRS |
| 2. | | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 | _____ MON/YRS |
| 3 | | .☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 | _____ MON/YRS |

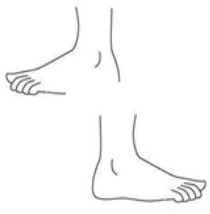
Please mark the area & type of pain on the drawings using the codes listed below. **RIGHT** **LEFT**

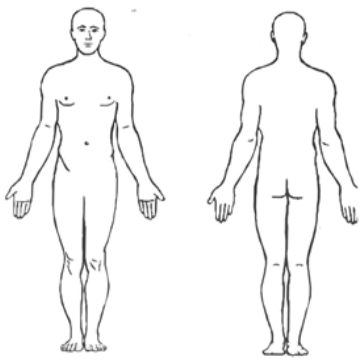
P Pain T Tingling S Soreness
N Numbness A Ache ST Stiffness



LEFT

RIGHT





****** PLEASE CONTINUE ON NEXT PAGE ******

## History of Chief Complaint (Check the boxes that most apply to your condition)

What is the **PRIMARY SENSATION** of your symptoms? ☐ **PAIN**
☐ Numbness
☐ **Tingling** ☐ Loss of Sensation ☐ **Loss of Strength** ☐ Loss of Coordination
☐ Other: _____

What IS THE **PRIMARY LOCATION** of your symptoms?
☐ Right Side ☐ Left Side ☐ Both Sides ☐Upper body ☐ Lower body
☐ **Legs** ☐ Calf ☐ **Feet** ☐ Ankle ☐ **Shoulder** ☐ Wrist ☐ Neck ☐ Back ☐ **Whole Body**
☐ Other: _____

## Onset of Chief Complaint (Check all the boxes that applies)

Onset of Symptoms was ☐ Gradual ☐ Sudden
Symptoms are ☐ Chronic – meaning that they are relatively constant
☐ Acute – meaning that they are sudden and/or intermittent

## Patient symptom intensity Rate on a 1-10 scale: Check the correct number.

| | | | |
|---|---|---|---|
| **Pain** | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 | **Numbness** | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 |
| Tingling | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 | Tightness | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 |
| **Burning** | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 | **Soreness** | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 |
| Decreased Range of Motion | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 | Decreased Coordination | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 |

## Musculature symptoms (Check all that applies)

☐ **Weakness** ☐ Paralysis ☐ Foot drop ☐ Arm swing ☐ Poor hand grip ☐ Muscle spasms
☐ Other: _____

## Loss of coordination (Check all that applies)

☐ **Falls** ☐ Dropping items ☐ Stumbling ☐ Holding walls or furniture ☐ Other:
_____

## Associated symptoms (Check all that applies)

☐ Vertigo ☐ GI problems ☐ Thyroid ☐ Hair Loss ☐ cold intolerance
☐ hot intolerance ☐ Bowel/bladder incontinence

## Any sleep issues (Check all that applies)

☐ None ☐ Sleep apnea ☐ Insomnia ☐ Restless Leg Syndrome
☐ Sleep aid device ☐CPAP Machine ☐ Sleep Meds:_____

## Family history (Check all that applies)

Mother ☐ Heart ☐ CX ☐ Arthritis ☐ Other
Father ☐ Heart ☐ CX ☐ Arthritis ☐ Other Sibling ☐ Heart ☐ CX ☐ Arthritis ☐ Other

## Memory & Neuro (Check all that applies)

I am experiencing issues with ☐ **Memory** ☐ Cognition ☐ Awareness
This problem is ☐ **Mild** ☐ Moderate ☐ Severe

I currently use ☐ Alcohol ☐ Nicotine ☐ Illegal substances

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**Current/Previous Providers** (Check all that applies)

My prior doctors have included: ☐ **Primary Care Physician** ☐ **Neurologist** ☐ **Ortho/ Surgeon**

☐ Podiatrist ☐ Cardiologist ☐Chiropractor ☐ Acupuncture/Holistic medicine ☐ **Other** _____

**Previous Work-Up:** (Check all that applies)

I have had the following clinical workups: ☐ **Blood Work** ☐ Lab work ☐ **MRI** ☐ **Xray** ☐EMG ☐EEG ☐Brain Scan

☐ Other_____

**Traumas and surgeries**: (Check all that applies)

☐ Concussions ☐ Car accidents ☐ Slips & Falls ☐ **Childhood Injuries** _____

☐ Knee Surgery ☐ Spinal Surgery ☐ CTS Surgery ☐ **Other Surgery** _____

**Prior treatments include:** (Check all that applies)

☐ Toradol injections ☐ TENS therapy ☐ Corticosteroid/joint injections ☐ **Other Treatments**_____

What makes your symptoms worse?_____

What makes your symptoms better? _____

**Medications:** (Check all that applies)

☐ **Metformin** ☐ Insulin ☐ Coumadin ☐ **Lisinopril** ☐ **Gabapentin**

☐ Lyrica ☐ Cymbalta ☐ Atenolol ☐ **Statins** ☐ **Thyroid RX**

☐ Other _____

| | | | |
|---|---|---|---|
| **Have you been diagnosed with Diabetes?** | ☐ Yes Number of Years? | | ☐ No |
| Is your blood sugar | ☐ Managed and stable | | ☐ unstable |
| What is your Blood Sugar level ? | ☐ Normal | ☐ Moderately Elevated | ☐ Extremely Elevated |
| What is your Hgb A1C level ? | ☐ Normal | ☐ Moderately Elevated | ☐ Extremely Elevated |

**Do you have any other conditions which may affect your health?** (Check all that applies)

| | | | | |
|---|---|---|---|---|
| ☐ HIGH BLOOD PRESSURE | ☐ HEART DISEASE | ☐ CHEMO THERAPY | ☐ KIDNEY DISEASE | ☐ BPH |
| ☐ LIVER ISSUES | ☐ PROSTATE CANCER | ☐ BREAST CX | ☐ SEIZURES | ☐ NONE |

**List Name and address of location of Previous records** ☐ No records available

Clinic Name: Address:

Clinic Name: Address:

*What are your health goals in relation to your symptoms:* ***What would you consider a successful outcome?***

_____

**Patient Signature** _____ **Date** _____