Dr. Allison Zak D.C. LLC

Patient Health History

Patient Name: _____ **DOB:** _____ **Date:** _____

Describe the areas you are having symptoms/pain: _____

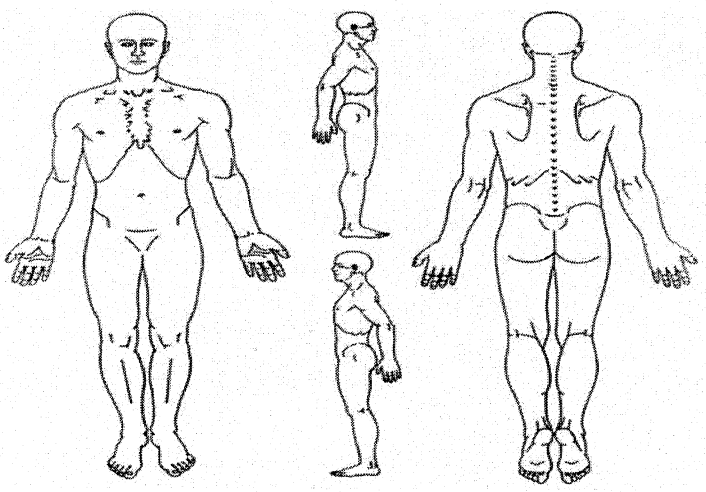
_____

How did your symptoms start: _____

When did your symptoms start:_____ **Have you had this condition in the Past:**__Yes __No

Have you seen any other provider for this condition: __Yes __No **If yes, who have you seen:** _____

Please mark where you are having symptoms:



How often do you experience the pain:

___ Constantly (76-100% of the day)
___ Frequently (51-75% of the day)
___ Occasionally (26-50% of the day)
___ Intermittently (0-24% of the day)

How would you describe your pain:

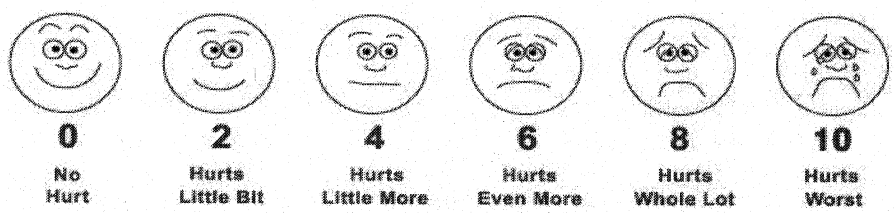
___Sharp ___Shooting ___Dull Ache
___Numb ___Tingling ___Burning
___Stings ___Pounding ___Cramping

Do any of the following relieve your pain:

___Resting ___Hot Shower ___Ice
___Exercise ___Laying Down ___Sitting
___Stretching ___Ibuprofen
___Other_____

On a scale of 0-10 how would you rate your pain as of today's visit:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10



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Patient Health History Page 2

Patient Name: _____ **DOB:** _____

In the past week my condition is: ___Improving ___ Getting Worse ___About the Same

Do any of the following aggravate your symptoms?

___Lifting ___Standing ___Sitting ___Bending ___Coughing ___Sneezing
___Stress ___Exercising ___Pushing ___Walking ___Getting in/out of the car
Other_____

This condition is interfering with your:

___Job ___Sleep ___Daily Routine ___Hobbies ___Bowels/Urine Other:_____

Stress Level at home:
___Heavy ___Moderate ___Light

Stress Level at work:
___Heavy ___Moderate ___Light

Are you a current tobacco user:
___ Yes ___No

Physical activity level at work:
___Heavy ___Moderate ___Light

Physical Exercise Routine:
___Heavy ___Moderate ___Light

Height: ____Ft ____In. **Weight:** _____lbs.

Please list any medications and nutritional supplements you are currently taking:

_____

_____

Please list any surgeries you have had: _____

_____

Do you have a pacemaker: ___Yes ___No

(Females Only) Are you currently pregnant: ___Yes ___No **If Yes, How many weeks:** _____

Patient Signature:_____ **Date:** _____