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To reproduce, follow the printing instructions.

Direction of Feed

Personal / Family History

Please answer every question

*Handwritten items must be entered **MANUALLY**.*
Do not fold this form.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH Month Day Year

When did this problem first start? _____

Was this due to an accident? yes ◯ no ◯ **If yes, what was the accident date:** _____

Is there a legal case pending? yes ◯ no ◯

Is there a worker's compensation case? yes ◯ no ◯

TOBACCO USE

What is your smoking status? current (every day) ◯ current (some days) ◯ previous ◯ never ◯

At what age did you begin smoking?

If you quit smoking, at what age did you quit?

How many cigarettes do you currently smoke (or did you previously smoke) **per day?**

EXAMPLE
If you started smoking at the age of 21, you would fill in the ovals like this:
10 ◯ 20 ● 30 ◯
1 ● 2 ◯ 3 ◯

10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

How many cigars or pipes do you smoke per week? 0 ◯ <1 ◯ 1-2 ◯ 3-5 ◯ 6-9 ◯ 10+ ◯

How many cans of smokeless / chewing tobacco do you use per week? 0 ◯ <1/2 ◯ 1/2 ◯ 1 ◯ 2 ◯ 3+ ◯

Are you exposed to secondhand smoke? yes ◯ no ◯

ALCOHOL USE

How often do you drink alcohol? **Number of times:** never ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7+ ◯
Per: week ◯ month ◯ year ◯

(If you marked "never", please skip ahead to DRUG USE section)

What type(s) of alcohol do you drink? beer ◯ wine ◯ liquor ◯

How many drinks do you have per occasion? 1-2 ◯ 3-5 ◯ 6-9 ◯ 10+ ◯

How often do you have more than five drinks per occasion? never ◯ occasionally ◯ rarely ◯ frequently ◯

DRUG USE

none ◯ current ◯ previous ◯ prefer to discuss with physician ◯

HIV HIGH RISK BEHAVIOR?

(HIV Risk Factors: IV drug use, more than one sexual partner, sex with a prostitute, unprotected sexual contact, contact with contaminated injection equipment.)

yes ◯ no ◯ prefer to discuss with physician ◯

HABITS

Caffeine
Type(s) of caffeine: coffee ◯ tea ◯ soft drinks ◯
Drinks per day: occasionally ◯ 0 ◯ 1-2 ◯ 3-5 ◯ 6-9 ◯ 10+ ◯

Exercise
Type(s) of exercise: bicycling ◯ running ◯ swimming ◯ walking ◯ aerobics ◯ other ◯
Times per week: occasionally ◯ 0 ◯ 1-2 ◯ 3-4 ◯ 5-6 ◯ 7+ ◯

*For technical support, please contact PatientLink at **Support@MyPatientLink.com.***

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Direction of Feed

Personal / Family History

Please answer every question

*Handwritten items must be entered **MANUALLY**. Do not fold this form.*

You are: right-handed ◯ left-handed ◯

What is your occupation? _____

Are you currently working? yes ◯ no ◯

How many children do you have? NONE ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10+ ◯

TREATMENTS

What treatments have you tried for your problem:

- ◯ Bracing
- ◯ Chiropractic Manipulation
- ◯ Epidural Steroid Injections
- ◯ Heat / Ultrasound
- ◯ Massage
- ◯ Medications
- ◯ Physical Therapy
- ◯ Spine Exercises
- ◯ TENS Unit
- ◯ Traction
- ◯ **Other** (please specify): _____

CHILDHOOD ILLNESSES

What childhood illnesses have you had:

- ◯ Chicken Pox
- ◯ Rubella
- ◯ Measles
- ◯ Mumps
- ◯ Rheumatic Fever
- ◯ Scarlet Fever
- ◯ **Other** (please specify): _____

PAST MEDICAL HISTORY

Please indicate if YOU have a history of the following:

- ◯ AIDS / HIV
- ◯ Anemia
- ◯ Cancer (type): _____ (location): _____
- ◯ Diabetes
- ◯ Emphysema
- ◯ GERD
- ◯ Glaucoma
- ◯ Heart Attack
- ◯ Heart Disease
- ◯ Heart Murmur
- ◯ Hemophilia
- ◯ Hemorrhoids
- ◯ Hepatitis
- ◯ Hernia
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ Kidney Stones
- ◯ Liver Disease
- ◯ Osteoarthritis
- ◯ Osteoporosis
- ◯ Pacemaker
- ◯ Peptic Ulcer
- ◯ Phlebitis
- ◯ Prostate Cancer
- ◯ Rheumatoid Arthritis
- ◯ Sinusitis
- ◯ Skin Cancer
- ◯ Thyroid Disease
- ◯ **Other** (please specify): _____
- ◯ **NONE**

FAMILY MEDICAL HISTORY

◯ **Family History UNKNOWN** ◯ **NO SIGNIFICANT FAMILY MEDICAL HISTORY**

Please indicate which family members have had these illnesses:	Father	Mother	Brother	Sister	Son	Daughter
Arthritis	◯	◯	◯	◯	◯	◯
Cancer	◯	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯	◯
Heart Attack	◯	◯	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯	◯	◯
Lung Disease	◯	◯	◯	◯	◯	◯
Multiple Sclerosis	◯	◯	◯	◯	◯	◯
Seizures	◯	◯	◯	◯	◯	◯
Spine Problems	◯	◯	◯	◯	◯	◯
Stroke	◯	◯	◯	◯	◯	◯
Tuberculosis	◯	◯	◯	◯	◯	◯
OTHER (please specify): _____	◯	◯	◯	◯	◯	◯

SURGERIES

Please list your surgical procedures, your age at the time of the surgery and your surgeon's name:

Procedure: _____ **Age:** _____ **Surgeon's Name:** _____

Procedure: _____ **Age:** _____ **Surgeon's Name:** _____

Procedure: _____ **Age:** _____ **Surgeon's Name:** _____