align SPINE CENTER
Making A Difference One Level At A Time

Date: _____

PATIENT HISTORY FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES			
FIRST NAME	**LAST NAME**	**SEX**	**DATE OF BIRTH**
REFERRED BY	**RECENT DOCTOR EVALUATION**	**HEIGHT**	**WEIGHT**
DOMINANT HAND?	**DATE OF INJURY**	**IS THERE LITIGATION?**	

RECENT IMAGING	**RECENT INJECTIONS**	**RECENT TREATMENT**	**HAVE YOU HAD ANY OF THE FOLLOWING?**
☐ X-RAY	☐ EPIDURAL	☐ PHYSICAL THERAPY	☐ FEVER
☐ MRI	☐ FACET	☐ CHIROPRACTOR	☐ CHILLS
☐ CT	☐ TRIGGER POINT	☐ ACCUPUNCTURE	☐ BOWEL / BLADDER CHANGES
☐ MYELOGRAM	☐ OTHER	☐ MEDROL DOSE PACK	☐ WEIGHT LOSS
			☐ SLEEP DIFFICULTY

ALLERGIES
CURRENT MEDICATIONS
PAST MEDICAL HISTORY
PAST SURGICAL HISTORY

FAMILY HISTORY *(WHO / WHAT TYPE)*
BLEEDING PROBLEMS
DIABETES
CANCER
HEART DISEASE
OTHER

SOCIAL HISTORY		
TOBACCO USE (TYPE)	**# PACKS PER DAY**	**# YEARS**
ALCOHOL USE (TYPE)	**# DRINKS PER WEEK**	**# YEARS**
ILLICIT DRUG USE (TYPE)	**# TIMES PER WEEK**	**# YEARS**