New Patient History/Clinical Interview:

These questions are designed to elicit as much information as possible about the patient's HPI. For multiple complaints, document the information separately.

A. Gather the chief complaint(s) first with: "What brings you in today?" or "How can I help you?"

1. When or approximately when did it start?

2. Did it begin gradually or suddenly?
    a. If gradually, over what period of time? How long to develop?

3. Did anything cause or contribute to the onset?

4. Have you ever had anything like this before?
    a. If yes, did it feel the same as this time? What was the outcome?

5. Can you point to the exact location of your symptom(s)? Describe.

6. Does it travel (radiate) to any other part of your body? Describe.

7. Do you have symptoms in any other part of your body?

8. Can you describe the sensation? (If necessary to prompt--dull, sharp, burning, aching, gnawing, throbbing, shooting, constricting, other)

9. How would you describe the intensity? (VAS scale 0-10)

10. Has it been constant or does it come and go?
    a. Constant: present 75% of the day or more
    b. Episodic: tied to a particular event or time of day (i.e. occurs every time the patient drives)
    c. Intermittent: not tied to a particular event or time of day (often unpredictable)

11. Has it been getting better, worse or staying about the same since its start?

12. Have you found anything that makes it better? (Rest, morning, evening, certain positions, other)

13. Have you found anything that makes it worse? (Positions, activities, morning, evening, coughing, sneezing, straining, other)

14. Has there been a change in any bodily functions? (Urination, defecation, respiration, digestion, vision, sexual, other)

15. Has it affected your daily activities in any way?

16. Have you tried any store bought, prescription, or home remedies?
    a. If yes, what was the effectiveness?

17. Have you sought other professional care for this condition? (Effectiveness – poor, good, excellent)
    a. If yes, what was the effectiveness?

18. Is there anything else you would like to discuss or you think would be important for me to know?

PAST HEALTH HISTORY (PHH)
"MIST" or "2 + MIST"

1. How would you rate your overall health? (0-10 VAS)
2. Have you gained or lost weight in the last year? (Amount and why)

MEDICATIONS:

3. Do you take any medications or supplements?
    a. Over the counter (aspirin, decongestants, vitamins)
    b. Prescription (birth control, blood pressure)
    c. Other drugs (alcohol, tobacco, recreational drugs)

ILLNESSES:

4. Do you **currently** suffer from any diseases or allergies?
5. Have you suffered from any other significant diseases or **allergies in the past**?
6. Have you had measles, mumps, chicken pox, or other common childhood illnesses?

SURGERIES:

7. Have you had any surgeries? (tonsils, appendix, hernia, Caesarian, transfusions)

TRAUMAS:

8. Have you had any injuries, accidents, broken bones, bad falls or blows to the head or body?
9. Do you use any supports, braces, wraps, heel lifts?

SOCIAL HISTORY: (SH)

1. Is your job stressful? How would you rate it on a scale of 0-10?
2. Is your home or personal life stressful? How would you rate it on a scale of 0-10?
3. How do you use your spare time? (sports, reading, hobbies, etc.)

OCCUPATIONAL HISTORY: (OH)

1. Does your current job require you to primarily sit, stand, walk, other?
2. Does your current job require lifting and/or twisting?
3. Does your job involve jarring or jolting forces to the spine or extremities? Vibrating machinery?
4. Does your job require your head or body to be bent forward, backward, to the side or twisted repeatedly or for extended periods?
5. Have you ever worked or lived somewhere where you were exposed to toxic metals, gases, fumes, dusts, radioactive material or chemicals?

HABITS: (BRED)

BEVERAGES:

1. Do you drink any of the following on a regular basis – coffee, tea, alcohol, sweetened juices, carbonated beverages, milk, water? (Frequency and amount)

REST:

2. Are you getting adequate sleep? How much?
3. What type of sleeping surface do you use?
4. Do you sleep primarily on your back, side or stomach?
5. Do you read, watch TV, or relax with your neck or back bent?

EXERCISE:

6. Do you have a regular exercise program? (What and frequency)

DIET:

7. Do you have a balanced diet of fruit, vegetables, meat, roughage, fish, foul, dairy products?
8. Are any of the following a main part of your diet? Sugar, oils, fats, salt? (Frequency and amount)

MARITAL HISTORY (MH):

1. Are you married, single, divorced, partnered, with or without children?
2. Is your spouse or partner in poor, fair, good, excellent health?
3. Are your children in poor, fair, good, excellent health?
4. Do any of your children suffer from diagnosed conditions?

FAMILY HISTORY (FH):

1. Is your father in poor, fair, good, excellent health? If deceased, why?
2. Is your mother in poor, fair, good, excellent health? If deceased, why?
3. Are your siblings in poor, fair, good, excellent health? If deceased, why?
4. Do any of your family members have any diagnosed conditions?