Dr. Ryan L. Villwok, D.C., P.C.
New Patient Health History Form

Patient Name:_____
DOB:_____

Medications

Medications	Dose

Allergies

Allergy	Severity

Past Surgeries

Surgery	Date

Back Pain

Location:
___ No back pain
___ Centrally located low back pain
___ Right sided low back pain
___ Left sided low back pain
___ Both sides into the hips
___ Between the shoulder blades

Describe Your Pain:
___ Deep dull
___ Sharp
___ Burning
___ Electric
___ Hot/tingling
___ Stiff and sore

When did your back pain begin?
___ After my accident
___ Years ago (Date)_____
___ A few days/weeks/months ago
___ Always had some pain/stiffness

Intensity:
___ Mild (1-3)
___ Moderate (4-7)
___ Severe (8-10)

Duration:
___ Constant
___ Intermittent

Have you had this pain in the past?
___ Yes ___ No

Previous treatment for back pain?
___ Yes ___ No

Does your pain radiate?
___ Does not radiate to legs/feet/toes
___ Radiates into the **right** leg
___ Radiates into the **left** leg
___ Radiates into the **right** foot/toes
___ Radiates into the **left** foot/toes

How well do you function with your pain?
___ I have 100% function with usual activities
___ I have 75% function with usual activities
___ I have 50% function with usual activities
___ I have 25% function with usual activites
___ I cannot function

What makes your pain worse?
___ Flexion
___ Extension
___ Motion
___ Laying on back
___ Rotating left/right
___ Coughing/Sneezing
___ Laying on side

What makes your pain better?
___ Cold/Ice
___ Heat
___ Massage
___ Exercise and stretching
___ Rest
___ Laying on side
___ Laying on back

Dr. Ryan L. Villwok, D.C., P.C. Patient Name:_____

New Patient Health History Form pg2 DOB:_____

Neck Pain

Location:
___ No neck pain
___ Centrally located low neck pain
___ Right sided low neck pain
___ Left sided low neck pain
___ Both sides into the shoulders
___ At the base of the skull

Describe Your Pain:
___ Deep dull
___ Sharp
___ Burning
___ Electric
___ Hot/tingling
___ Stiff and sore

When did your back pain begin?
___ After my accident
___ Years ago (Date)_____
___ A few days/weeks/months ago
___ Always had some pain/stiffness

Intensity:
___ Mild (1-3)
___ Moderate (4-7)
___ Severe (8-10)

Duration:
___ Constant
___ Intermittent

Have you had this pain in the past?
___ Yes ___ No

Previous treatment for back pain?
___ Yes ___ No

Does your pain radiate?
___ Does not radiate to arms/hands/fingers
___ Radiates into the **right** arm
___ Radiates into the **left** arm
___ Radiates into the **right** fingers
___ Radiates into the **left** fingers

How well do you function with your pain?
___ I have 100% function with usual activities
___ I have 75% function with usual activities
___ I have 50% function with usual activities
___ I have 25% function with usual activites
___ I cannot function

What makes your pain worse?
___ Moving head up
___ Moving head down
___Rotating left/right
___ Motion
___ Coughing/Sneezing

What makes your pain better?
___ Cold/Ice
___ Heat
___ Massage
___ Rest
___ Medication

Headaches

Location:
___ No headaches
___ Forehead
___ Right side of head
___ Left side of head
___ Behind my eyes
___ Back of head

Describe Your Pain:
___ Deep pressure
___ Dull ache
___ Burning
___ Throbbing
___ Hot/tingling
___ Stiff and sore

When did your back pain begin?
___ After my accident
___ Years ago (Date)_____
___ A few days/weeks/months ago
___ Always had some pain/stiffness

History:
___ History of headaches?
___ Ever suffered a concussion?
___ Prior epilepsy treatment?
___ Prior history of seizures?

Intensity:
___ Mild (1-3)
___ Moderate (4-7)
___ Severe (8-10)

Duration:
___ per week

What makes your pain worse?
___ Noise
___ Light
___Food
___ Motion
___ Coughing/Sneezing

What makes your pain better?
___ Cold/Ice
___ Heat
___ Massage
___ Rest
___ Medication