Welcome!

PATIENT INFORMATION

Date: _____

Name: _____ I prefer to be called: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____
Date of Birth: _____ Are you: Married ☐ Single ☐ Widowed ☐ Divorced ☐ Minor ☐
Occupation: _____ Your Employer: _____
How did you hear about our office? _____
Person to contact in case of emergency: _____ Phone: (____)_____
Email Address: _____
Primary Physician: _____ Physician's Clinic: _____

What brings you to the office today? _____

How long have you had it? _____

How often does it occur? _____

What does it feel like? _____

What makes it worse? _____

What have you done that has helped this problem? _____

What activities would you like to do if this was not a problem? _____

Does this cause you to be:	Does this affect your work:	Does this affect your life:
☐ Moody	☐ Decision making	☐ Lose patience with spouse
☐ Irritable	☐ Poor attitude	☐ Restricted household duties
☐ Interrupt sleep	☐ Decreased productivity	☐ Hinders ability to exercise/sports
☐ Restricted daily activities	☐ Exhausted at the end of day	☐ Interferes with hobbies/activities

What have you tried to help relieve or get rid of this problem and how much did it help? (please circle)

☐ Medications	None	Some	Much	☐ Massage	None	Some	Much
☐ Physical Therapy	None	Some	Much	☐ Injections	None	Some	Much
☐ Chiropractic	None	Some	Much	☐ Stretching	None	Some	Much

Other: _____

_____

Signature: _____

Health History

Patient Name: _____ Signature: _____

Date: _____ Date of last physical examination: _____

Please mark any symptoms you have experienced in the past year **Mark any previously diagnosed conditions**

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Sweats

Eyes
- ☐ Crossed eyes
- ☐ Double vision
- ☐ Vision- flashes/ halos
- ☐ Blurred vision

Ears/Nose/Throat
- ☐ Earache
- ☐ Ear discharge
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Hay fever
- ☐ Sinus problem
- ☐ Nose bleeds
- ☐ Bleeding gums
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Persistent cough

Respiratory
- ☐ Shortness of breath
- ☐ Cough ☐ Congestion
- ☐ Distress ☐ Sputum

Genito-Urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Endocrine
- ☐ Weight gain/loss
- ☐ Heat/cold intolerance
- ☐ Breast changes
- ☐ Hair changes
- ☐ Extreme thirst

Gastrointestinal
- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting no blood
- ☐ Vomiting with blood

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Swelling of ankles
- ☐ Varicose veins

Women Only
- ☐ Bleeding between periods
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Date of last menstrual period: _____
- ☐ Date of last pap smear: _____ Normal? Y/N
- ☐ Have you had a mammogram? _____
- ☐ Are you pregnant?____
- ☐ Number of children?___

Men Only
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Genital sores

Integumentary
- ☐ Bruise easily
- ☐ Hives
- ☐ Change in moles
- ☐ Sores that won't heal
- ☐ Itching
- ☐ Unusual swelling
- ☐ Sores/ulcers
- ☐ Rash
- ☐ Scars

Neurological
- ☐ Seizures
- ☐ Vertigo
- ☐ Dizziness
- ☐ Hand trembling
- ☐ Loss of sensation
- ☐ Loss of facial expression
- ☐ Weak grip
- ☐ Paralysis
- ☐ Speech difficulty
- ☐ Tingling/numbness
- ☐ Memory loss
- ☐ Loss of coordination

Musculoskeletal
- ☐ Arms
- ☐ Legs
- ☐ Hands
- ☐ Feet
- ☐ Back
- ☐ Neck
- ☐ Shoulders
- ☐ Hips

Psychiatric
- ☐ Hyperventilation
- ☐ Insecurity
- ☐ Depression
- ☐ Trouble sleeping
- ☐ Irritability
- ☐ Anxiousness
- ☐ Hallucinations
- ☐ Drug/alcohol dependency
- ☐ Extreme worry
- ☐ Sexual problems
- ☐ Suicidal thoughts

Conditions
- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Bronchitis
- ☐ Breath shortness
- ☐ Cancer _____
- ☐ Cataracts
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pneumonia
- ☐ Prostate problems
- ☐ Psychiatric illness
- ☐ Rheumatoid Arth.
- ☐ Spinal stenosis
- ☐ Stroke
- ☐ Thyroid issues
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Other: _____

_____

_____

Are you taking any medications? Please list: _____

_____

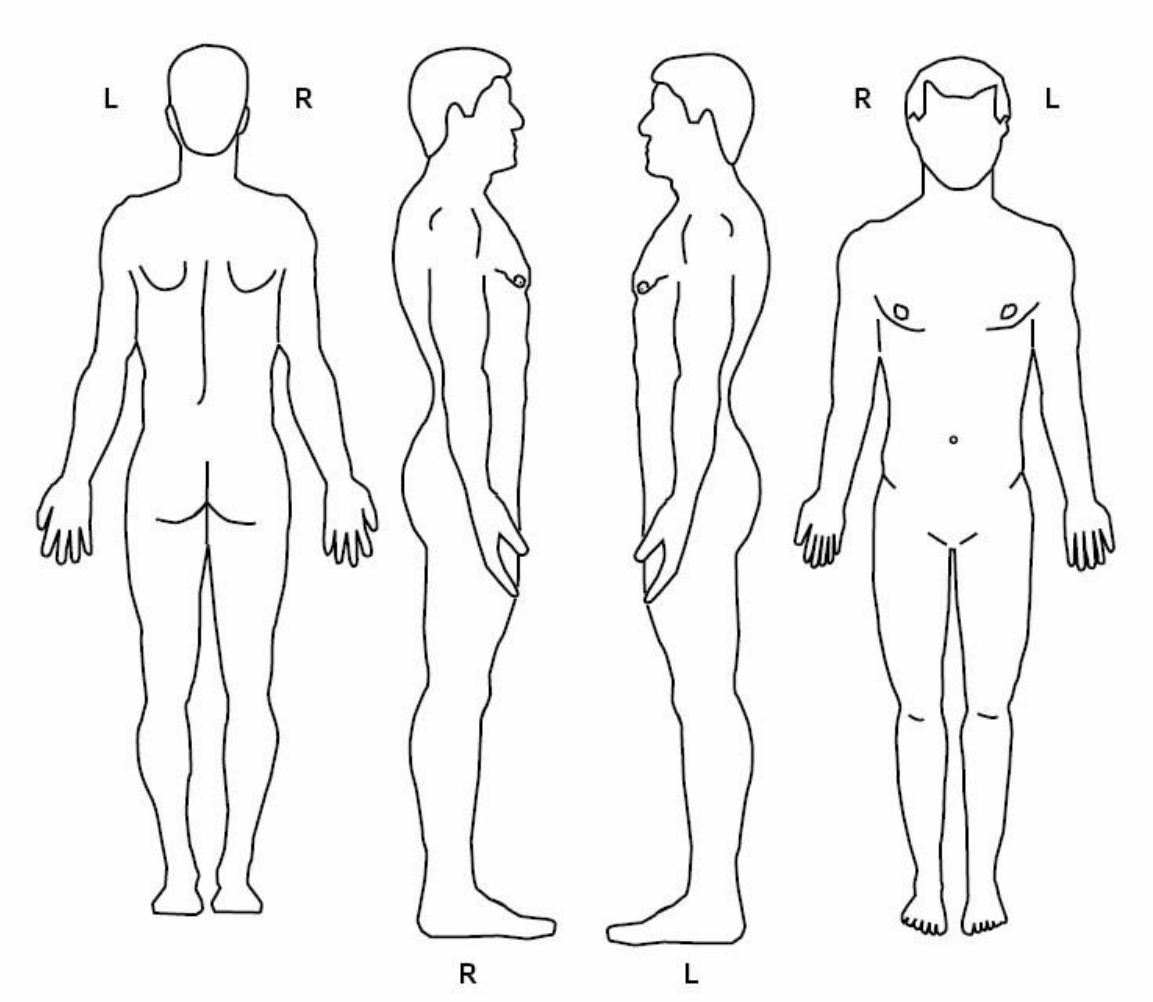
Do you have allergies to any medications or substances? Please list: _____

PAIN DRAWING

Name: _____ Date: _____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness ----------	Pins & Needles oooooooo	Burning xxxxxxxxx Pain xxxxxxxx	Stabbing ////////// Pain //////////	Aching (((((((((Pain (((((((



VISUAL ANALOGUE SCALE

Please mark on the line the pain level that most accurately represents your pain:

NO PAIN: 0 1 2 3 4 5 6 7 8 9 10 UNBEARABLE PAIN

a) Right Now:---- 0 1 2 3 4 5 6 7 8 9 10 _____

b) Average Pain 0 1 2 3 4 5 6 7 8 9 10 _____

c) At Best ------- 0 1 2 3 4 5 6 7 8 9 10 _____

d) At Worst------- 0 1 2 3 4 5 6 7 8 9 10 _____