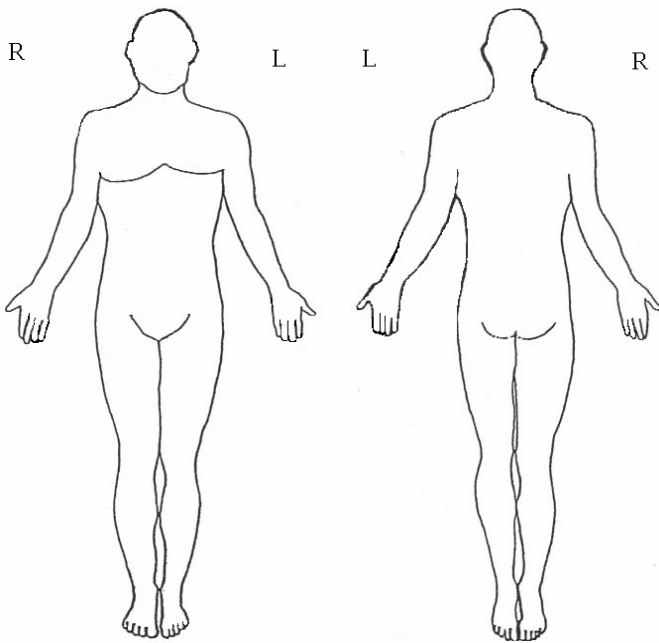


Name: _____ DOB: _____ Date: _____

Chief Complaint (reason for visit): _____

History of Present Illness:

- How long have you had these symptoms? _____
- Explain how this illness or injury occurred, if applicable: _____
- How severe is the pain, on a scale of 1-10? _____ Constant or intermittent? _____
- Any weakness? _____ Numbness or tingling? _____
- What relieves the pain/symptoms? _____
- What makes the pain/symptoms worse? _____
- Any similar symptoms in the past? _____



- Use the drawing to illustrate your symptoms. Indicate pain, numbness, or both.
- List any doctors you have seen for this condition and any treatment, medications, or recommendations given:

- Please list any physical therapy, chiropractic treatments, or injections. Include dates and results.

Past Medical History: (Please check all appropriate medical conditions; explain if necessary)

- ___ Heart problems
- ___ High blood pressure
- ___ Cancer
- ___ Lung disease
- ___ Sleep apnea
- ___ Diabetes
- ___ Kidney disease
- ___ Stroke or TIA
- ___ Thyroid disease
- ___ Blood clotting disorder
- ___ Vascular disease

- ___ Migraines or other chronic headaches
- ___ Seizures/Epilepsy
- ___ Neuropathy
- ___ Depression or psychiatric condition
- ___ Arthritis ___ Gout
- ___ Osteoporosis or osteopenia
- ___ Acid reflux, ulcers, or other gastrointestinal problems
- ___ Hepatitis, cirrhosis, or other liver disease
- ___ Deficient immune system
- ___ Other: _____

Name: _____ DOB: _____ Date: _____

Surgical and Other Medical History: (Please list all previous surgeries and hospitalizations)

Medication Allergies:

Medication	Reaction
_____	_____
_____	_____
_____	_____

Medications (Please list all current medications and their dosage; include herbals and supplements):

- | | |
|----------|-----------|
| 1. _____ | 8. _____ |
| 2. _____ | 9. _____ |
| 3. _____ | 10. _____ |
| 4. _____ | 11. _____ |
| 5. _____ | 12. _____ |
| 6. _____ | 13. _____ |
| 7. _____ | 14. _____ |

Are you in a medication contract with a pain management or other physician? Y N

Social History:

- Occupation: _____ Marital Status: _____
- Tobacco use: None _____ Current or previous tobacco use (specify): _____
- Alcohol use: Never _____ Rarely _____ Moderate _____ Daily _____
- Drug use (non-prescription): None _____ Type/Frequency _____
- History of alcohol or drug abuse problems? Y N

Family Medical History:

	<u>Age</u>	<u>Diseases</u>	<u>Cause of death, if applicable</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Name: _____ DOB: _____ Date: _____

Review of Symptoms (please specify if applicable):

Constitutional				Musculoskeletal		
Weight gain	N	Y		Neck pain	N	Y
Weight loss	N	Y		Back pain	N	Y
Fatigue	N	Y		Joint pain	N	Y
Poor appetite	N	Y		Joint stiffness	N	Y
Eyes				Muscle weakness	N	Y
Blurry vision	N	Y		Integument		
Double vision	N	Y		Skin problems	N	Y
Glaucoma	N	Y		Change in hair or nails	N	Y
Other eye disease	N	Y		Varicose veins	N	Y
ENT				Excessive sweating	N	Y
Hearing loss	N	Y		Breast pain	N	Y
ringing in ears	N	Y		Breast discharge	N	Y
Earaches	N	Y		Neurological		
Ear drainage	N	Y		Dizziness	N	Y
Sinus problems	N	Y		Lightheadedness	N	Y
Nose bleeds	N	Y		Seizures	N	Y
Cardiovascular				Spasticity	N	Y
Chest pain	N	Y		Tremors	N	Y
Palpitations	N	Y		Numbness/tingling	N	Y
Swelling of feet, ankles	N	Y		Paralysis	N	Y
Poor circulation	N	Y		Head injury	N	Y
Respiratory				Psychiatric		
Shortness of breath	N	Y		Memory loss/confusion	N	Y
when lying flat	N	Y		Depression	N	Y
Frequent cough	N	Y		Insomnia	N	Y
COPD	N	Y		Delusions or hallucinations	N	Y
Asthma	N	Y		Endocrine		
Sleep apnea	N	Y		Hormone problems	N	Y
GI				Excessive thirst	N	Y
Ulcers	N	Y		Excessive appetite	N	Y
Heartburn/acid reflux	N	Y		Change in hat or glove size	N	Y
Constipation	N	Y		Heme/Lymph		
Frequent diarrhea	N	Y		Easy bruising	N	Y
Nausea/vomiting	N	Y		Excessive bleeding	N	Y
Blood in stool	N	Y		Slow or poor wound healing	N	Y
GU				Anemia	N	Y
Frequent urination	N	Y		Enlarged glands/lymph nodes	N	Y
Burning with urination	N	Y		Previous blood transfusion	N	Y
Blood in urine	N	Y		Frequent or serious infections	N	Y
Incontinence	N	Y		HIV or AIDS	N	Y
Kidney stones	N	Y				
Sexual difficulties	N	Y				
(Male) Prostate problems	N	Y				
(Female) Painful periods	N	Y				
Irregular periods	N	Y				
Pregnancies: _____						
Miscarriages: _____						
Last period: _____						

				Patient Signature		

				Doctor Signature		