

All information is treated as strictly confidential. The more fully you complete this form, the better we will be able to diagnose and treat you.

Name: _____ DOB: _____ Age: _____

Office Use Only: Temp _____ HR _____ BP _____ RR _____ HT _____ WT _____ BMI _____

CHIEF COMPLAINT (Why are you seeing doctor today?)

 Location of Pain: Head Neck Back Other _____ Date Started: _____

 Does the Pain extend into your ARMS or LEGS? Yes No

How bad is your pain on a scale of 1-10 (1 = minimal & 10 = worst) At its Best: _____ At its Worst: _____

What makes it - Better _____ Worse _____

 Have you been treated with: Physical Therapy Chiropractor Pain Management NSAIDS (Advil/Aleve)

CURRENT AND PAST MEDICAL PROBLEMS
 Hypertension Diabetes Osteoporosis _____

SURGERIES
YEAR
ANY COMPLICATIONS

MEDICAL ALLERGIES
ALLERGY SYMPTOMS

CURRENT MEDICATIONS (RX or OTC)
STRENGTH / DOSAGE (attach list for numerous meds)

Blood Thinner's? _____

SOCIAL HISTORY

Occupation: _____

 Marital Status: Single Married Divorced Widow

 Children: Yes No How Many? _____

 Do you Smoke? Yes No Quit _____ how long Never Smoked

 Cigarettes _____ packs per day for _____ year's Cigars/Pipe Smokeless Tobacco

 Do you drink Alcohol? Never Rarely Socially Regularly

FAMILY HISTORY

	Alive	Age	Medical Problems	Deceased	Cause of Death
Father	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____
Sister/Brother	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____
Sister/Brother	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____

MEDICAL REVIEW

* Check all that apply *

	<u>Current Problem</u>	<u>Past Problem</u>		<u>Current Problem</u>	<u>Past Problem</u>
<u>Allergy / Immunological</u>			<u>Heart</u>		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Last EKG _____	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain when walking	<input type="checkbox"/>	<input type="checkbox"/>
<u>Constitutional / General Body</u>			<u>Musculoskeletal</u>		
Excessive Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Ache	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Spasms	<input type="checkbox"/>	<input type="checkbox"/>
<u>Ear, Nose, Throat, & Mouth</u>			<u>Neurological</u>		
Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>	Blackout spells	<input type="checkbox"/>	<input type="checkbox"/>
Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Coordination Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Inability to Smell	<input type="checkbox"/>	<input type="checkbox"/>	Double/Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Facial Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Ringings of Ears	<input type="checkbox"/>	<input type="checkbox"/>	Speech Difficulty	<input type="checkbox"/>	<input type="checkbox"/>
<u>Eyes</u>			<u>Psychiatric</u>		
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Bipolar	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Vision Loss	<input type="checkbox"/>	<input type="checkbox"/>	<u>Respiratory</u>		
<u>Endocrine</u>			Last Chest X-ray _____		
Diabetes Type I	<input type="checkbox"/>	<input type="checkbox"/>	Oxygen Use	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type II	<input type="checkbox"/>	<input type="checkbox"/>	CPAP Use	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Urination	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Hormone Problems	<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
<u>Gastrointestinal</u>			Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Vomit	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<u>Skin / Integumentary</u>		
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Last Mammogram _____		
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Breast Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Skin Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Sores or Abscesses	<input type="checkbox"/>	<input type="checkbox"/>
<u>Hematology / Blood Disorder</u>			Thin Skin	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<u>Any Other Types Cancer</u>		
Free Bleeder	<input type="checkbox"/>	<input type="checkbox"/>	_____		
<u>Genitourinary</u>			<u>Any Types of Stents</u>		
Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>			
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>			
Trouble Starting/Stopping Stream of Urine	<input type="checkbox"/>	<input type="checkbox"/>			
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>			
UTI	<input type="checkbox"/>	<input type="checkbox"/>			
Uterine/Cervical Cancer	<input type="checkbox"/>	<input type="checkbox"/>			

The above information is accurate to the best of my knowledge.

PATIENT SIGNATURE: _____ DATE: _____