

Name _____ Nickname _____ How did you hear about us _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Home Email _____ Date of Birth _____ Age _____ Gender Male Female Unspecified

Emergency Contact: _____ Contact Phone # _____

Marital Status Single Married Other Children YES NO How Many _____

Employment Status Employed FT Student PT Student Other Retired Self Employed

Occupation _____ Employer _____ Employer Phone _____

Do you have insurance? Yes No Insurance Name: _____

Primary insured? Yes No If no, primary insured name and relationship to self: _____ Their DOB _____

Family Physician _____ Phone _____

Current medications. COMPLETE FULLY:

RX Medication/Over The Counter	Why taken & Dosage	RX Medication/Over The Counter	Why taken & Dosage
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

List any known allergies you have had to any medications, foods or environment:

1) _____ 3) _____

2) _____ 4) _____

Do you suffer from seasonal allergies? Yes No If Yes, have you had allergy testing before? Yes No

Do you suffer from food sensitivity? Yes No If Yes, have you had food sensitivity testing before? Yes No

Health History: Please mark any condition you have now or had in the past

- | | | | | | |
|---|---|--|--|---|--|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Lesions |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Leaky Bladder | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Strength Loss |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Constipation | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Short of Breath | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Coughing | <input type="checkbox"/> Fainting | <input type="checkbox"/> Abdominal Pain | Frequency _____ |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Chronic Sore Throat | <input type="checkbox"/> Asthma | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Difficult Hearing | <input type="checkbox"/> Difficult Breathing | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Sinus Trouble | _____ |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Tremors | <input type="checkbox"/> Numbness | <input type="checkbox"/> Ear Ringing | _____ |

FAMILY HISTORY: Please check any condition that YOU or YOUR FAMILY have or have had in the past. **Please state (P) for Patient or (F) for family

- | | | | | | |
|--|----------|--|----------|--|----------|
| <input type="checkbox"/> Alcoholism | (P or F) | <input type="checkbox"/> High Blood Pressure | (P or F) | <input type="checkbox"/> Stroke | (P or F) |
| <input type="checkbox"/> Anemia | (P or F) | <input type="checkbox"/> Kidney Disease | (P or F) | <input type="checkbox"/> Suicide Attempt | (P or F) |
| <input type="checkbox"/> Asthma | (P or F) | <input type="checkbox"/> Liver Disease | (P or F) | <input type="checkbox"/> Thyroid Disease | (P or F) |
| <input type="checkbox"/> Cancer/Tumor | (P or F) | <input type="checkbox"/> Hepatitis | (P or F) | <input type="checkbox"/> Heart Disease | (P or F) |
| <input type="checkbox"/> Diabetes | (P or F) | <input type="checkbox"/> Lung Disease | (P or F) | <input type="checkbox"/> Ulcers | (P or F) |
| <input type="checkbox"/> Drug Abuse | (P or F) | <input type="checkbox"/> Rheumatic Arthritis | (P or F) | <input type="checkbox"/> HIV or Other Immune Disease | (P or F) |
| <input type="checkbox"/> Depression | (P or F) | <input type="checkbox"/> Osteoarthritis | (P or F) | <input type="checkbox"/> High Cholesterol | (P or F) |
| <input type="checkbox"/> Epilepsy/Seizures | (P or F) | <input type="checkbox"/> Osteoporosis | (P or F) | <input type="checkbox"/> Rash/ Itching | (P or F) |
| <input type="checkbox"/> Abnormal Pap | (P or F) | <input type="checkbox"/> Eye Problems | (P or F) | <input type="checkbox"/> Abnormal Mammo | (P or F) |
| <input type="checkbox"/> Other _____ | | | | | |

Patient Signature: _____ Date: _____

Dr Initials _____

1st Chief Complaint: _____

Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

When did it start? _____ Gradual / Sudden

Circle the percentage of the day you experience the complaint:
10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

2nd Chief Complaint : _____

Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

When did it start? _____ Gradual / Sudden

Circle the percentage of the day you experience the complaint:
10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

3rd Chief Complaint: _____

Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

When did it start? _____ Gradual / Sudden

Circle the percentage of the day you experience the complaint:
10 20 30 40 50 60 70 80 90 100

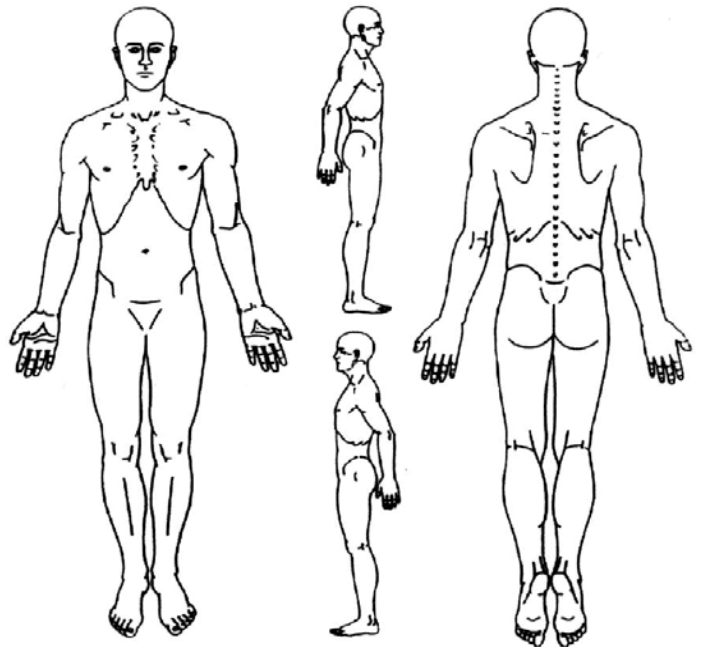
How would you rate the pain at its worst? (1 – 10) _____

Using the letters below, please show where you are experiencing all of your current complaints:

Do you have pain and/or difficulty performing any of the following activities?

- Personal Care
- Lifting
- Reading
- Concentrating
- Work
- Driving
- Sleeping
- Recreation
- Walking
- Sitting
- Standing
- Social Life

- A: Ache
- B: Burning
- C: Cramping
- D: Dull Pain
- F: Stiffness
- N: Numbness
- R: Throbbing
- S: Soreness
- T: Tingling
- X: Sharp Pain
- SP: Shooting Pain
- RP: Radiating Pain



Have you ever had tests for your present condition? MRI X-ray CT Other _____

Do you have a pacemaker? Yes No

Do you drink alcohol? Yes No If Yes, what is frequency _____

Do you currently smoke tobacco of any kind? Yes No Former smoker If yes, how often do you smoke? _____

When was your last Physical examination? _____

When did you last have blood work? Within a Year Over a Year Not Sure

Surgeries? Yes No If yes, list: _____

Trauma History: Please list any traumas you have had throughout your life, even back to childhood. Include athletic injuries, auto accidents, and falls: _____

