

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please place a check (✓) if you **NOW have** any of following:

**GENERAL**

- Allergy
- Chills
- Convulsions
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Heat/cold intolerance
- Loss of sleep
- Mental or emotional disorders
- Nervousness
- Neuralgia
- Numbness
- Sweats
- Tremors
- Weight change

**MUSCLE AND JOINT**

- Bone fractures
- Foot trouble
- Joint dislocations
- Joint stiffness
- Low-back pain
- Neck pain or stiffness
- Pain in mid-back
- Pain or numbness in:
  - Shoulders
  - Arms
  - Elbows
  - Hands
  - Hips
  - Legs
  - Knees
  - Feet
  - Ribs
- Painful tailbone
- Poor posture
- Sciatica
- Spinal curvature
- Sprains/strains
- Swollen joints

**NEUROLOGICAL**

- Seizures
- Syncope
- Sensory disturbances
- Stroke
- Head trauma

**GASTROINTESTINAL**

- Abdominal pain
- Belching or gas
- Black or bloody stool
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Difficulty in swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Heartburn
- Hemorrhoids
- Hernia
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Poor appetite
- Vomiting
- Vomiting of blood

**EYES, EARS, NOSE & THROAT**

- Asthma
- Colds
- Crossed eyes
- Dental decay
- Difficulty hearing
- Earache
- Ear discharge
- Ear noises
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Far sightedness
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nose bleeds
- Sinus infection
- Sore throat
- Tinnitus
- Tonsillitis

**FOR MEN ONLY**

- Testicular mass
- Testicular pain

**CARDIOVASCULAR**

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Orthopnea
- Pain over heart
- Paroxysmal nocturnal dyspnea
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

**SKIN**

- Boils
- Bruise easily
- Change in mole
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

**RESPIRATORY**

- Chest pain
- Chronic cough
- Cough up blood
- Difficult breathing
- Spitting up phlegm
- Wheezing

**GENITO-URINARY**

- Bed-wetting
- Blood in urine
- Frequent urination
- Hesitancy
- Incontinence
- Intermittency
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Urethral discharge

**FOR WOMEN ONLY**

- Breast lump
- Breast pain
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge
- Are you pregnant?

Please place a check (✓) if you **now have** or **have ever previously had** any of following conditions:

- |   |   |  |   |  |
|---|---|--|---|--|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Cold sores       | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Measles            | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Gout          | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Shingles      |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Diphtheria       | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema           | <input type="checkbox"/> HIV/AIDS      | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Influenza     | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Lumbago       | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Ulcers        |
| <input type="checkbox"/> Chicken pox      | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Malaria       | <input type="checkbox"/> Polio              | <input type="checkbox"/> Other _____   |

Please **briefly** explain any hospitalizations or surgeries \_\_\_\_\_

What prescription or over-the-counter medications are you currently taking? \_\_\_\_\_

Who is your primary care doctor and when was your last visit? \_\_\_\_\_

Please place a check (✓) in the box that best describes you:

SOCIAL HISTORY	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please place a check (✓) in the box that best describes the effects of your current condition on daily activities:

ACTIVITY	No effect	Pain	No effect	Pain
Bending	<input type="checkbox"/>	<input type="checkbox"/>	Household chores	<input type="checkbox"/>
Carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	Lifting	<input type="checkbox"/>
Sit to stand	<input type="checkbox"/>	<input type="checkbox"/>	Pet care	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	Self care	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	Walking	<input type="checkbox"/>
Using the computer	<input type="checkbox"/>	<input type="checkbox"/>		

Is there any other information about your health history that we should be aware of? Please explain \_\_\_\_\_

Have you sought treatment from another doctor? \_\_\_\_\_ If yes, please provide a brief explanation \_\_\_\_\_

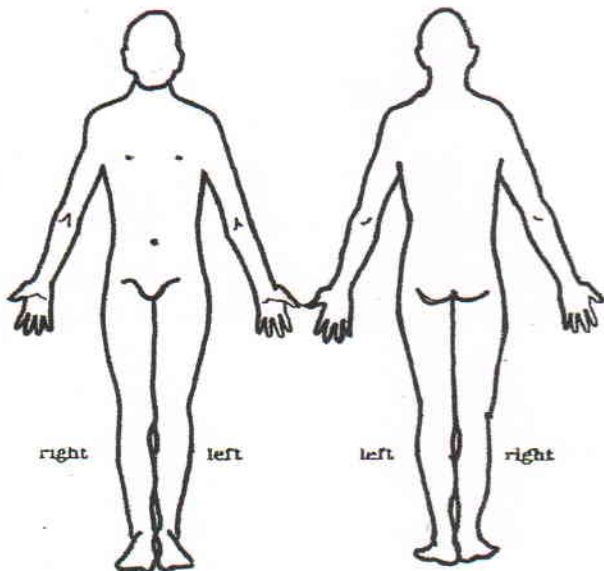
Mark on the pain scale from 0 to 10 the pain you feel: 0 \_\_\_\_\_ 10

No pain

Excruciating

Draw the appropriate symbol(s) on the body of where you feel the MOST pain:

Numbness      pins & needles      burning      aching      stabbing  
 ---              0 0 0              x x x              \* \* \*              / / /



Return When Complete