Name:_____ **Age:**_____ **Height:**_____ **Weight:**_____

Referred by?_____ **Family Physician?**_____

CHIEF COMPLAINT: (What is the reason for your visit?)_____

HISTORY OF PRESENT PROBLEM: When did your symptoms begin?_____
☐ Work Injury ☐ Auto Accident ☐ Spontaneous Onset ☐ Other_____

BRIEFLY DESCRIBE:_____

Ever had such symptoms in the past? ☐ Yes ☐ No Explain:_____

Is this injury part of an active Workers Compensation Claim? ? ☐ Yes ☐ No Claim #_____

Past treatments: ☐ Physical Therapy ☐ Chiropractic ☐ Nerve block ☐ Epidural injection ☐ Biofeedback
☐ Surgery ☐ Other:_____Briefly describe response:_____
Past tests: ☐ Labs ☐ X-rays ☐ MRI ☐ EMG☐ Other:_____
Since the onset of your problem, have your symptoms changed? ☐ Yes ☐ No If so, how?_____
_____

Are your symptoms: ☐ Constant ☐ Sharp ☐ Stabbing ☐ Burning ☐ Throbbing ☐ Intermittent ☐ Dull
☐ Shooting ☐ Aching ☐ Other_____
Do you experience: ☐ Numbness ☐ Tingling ☐ Weakness ☐ Other:_____
What increases your pain: ☐ Walking ☐ Lifting ☐ Lying ☐ Twisting ☐ Sitting ☐ Bending ☐ Standing
☐ Reaching ☐ Other:_____
What decreases your pain? ☐ Heat ☐ Rest ☐ Reclining ☐ Sitting ☐ Walking ☐ Ice ☐ Activity ☐ Standing
☐ Other:_____
Does pain interfere with? ☐ Work ☐ Daily Activities ☐ Social Life ☐ Hobbies ☐ Relationships

Where would you rate your pain? (mark an "x" on the line)

_____

No pain *Worst Pain Imaginable*

CURRENT MEDICATIONS

Medication Names	Strength	Times per Day	Condition Being Treated

PHARMACY NAME & CITY:_____

PHARMACY PHONE NUMBER:_____

ALLERGIES: (Medication, food/other)_____

OVER

MEDICAL HISTORY: Please check all that apply.

□ Stroke □ Heart Attack □ High blood pressure □ COPD/asthma □ Blood clots
□ Coronary artery disease □ Peripheral vascular disease/circulation problems
□ Diabetes □ Kidney disease □ Hepatitis □ Thyroid disease □ Cancer
□ Coagulation disorder □ Gastritis/ulcers/reflux □ Psychiatric treatments □ HIV/AIDS

PAST SURGERIES OR HOSPITALIZATIONS (AND YEAR): _____

_____

SOCIAL HISTORY:

Occupation:_____□Full time □ Part time □ Retired □ Not working □ Disability
Marital Status: **S M D W** Children:_____
Do you have a history of drug or alcohol abuse/dependency? □Yes □ No
Tobacco use: □No □ Yes _____Pack per day_____Years □ Former smoker
Alcohol use: □No □ Yes _____drinks per week

FAMILY HISTORY- (MARK YES / NO AND CIRCLE RELATIONSHIP)

Diabetes: Y / N (Mother-Father-Sibling)
High blood pressure: Y / N (Mother-Father-Sibling)
Heart disease: Y / N (Mother-Father-Sibling)
Rheumatoid Arthritis: Y / N (Mother-Father-Sibling)
Cancer: Y / N (Mother-Father-Sibling)
Lupus: Y / N (Mother-Father-Sibling)
Fibromyalgia: Y / N (Mother-Father-Sibling)
Stroke: Y / N (Mother-Father-Sibling)

Constitutional:
□ fever □ chills □ sweats □ weight loss □ weight gain □ sleepiness □ fatigue

Eyes, Ears, Nose, Mouth, Throat:
□ blurry vision □ double vision □ blind spots □ trouble chewing □ choking □ dry mouth

Cardiovascular:
□ palpitations □ chest pain □ fainting

Respiratory:
□ wheezing □ coughing □ shortness of breath

Gastrointestinal:
□ heartburn □ nausea □ vomiting □ constipation □ diarrhea

Genitourinary:
□ incontinence □ frequency □ hesitancy □ painful urination □ blood in urine

Neurological:
□ numbness □ tingling □ balance difficulties □ spasms □ burning

Musculoskeletal:
□ global weakness or myalgia □ focal weakness □ joint pain and swelling □ neck pain □ back pain

Psychiatric:
□ anxiety □ depression □ suicidal thoughts or attempts □ insomnia □ memory issues

Endocrine:
□ excessive thirst □ hair loss □ sexual problems

Integumentary: □ skin rashes □ eczema

Patient Signature:_____ Date:_____