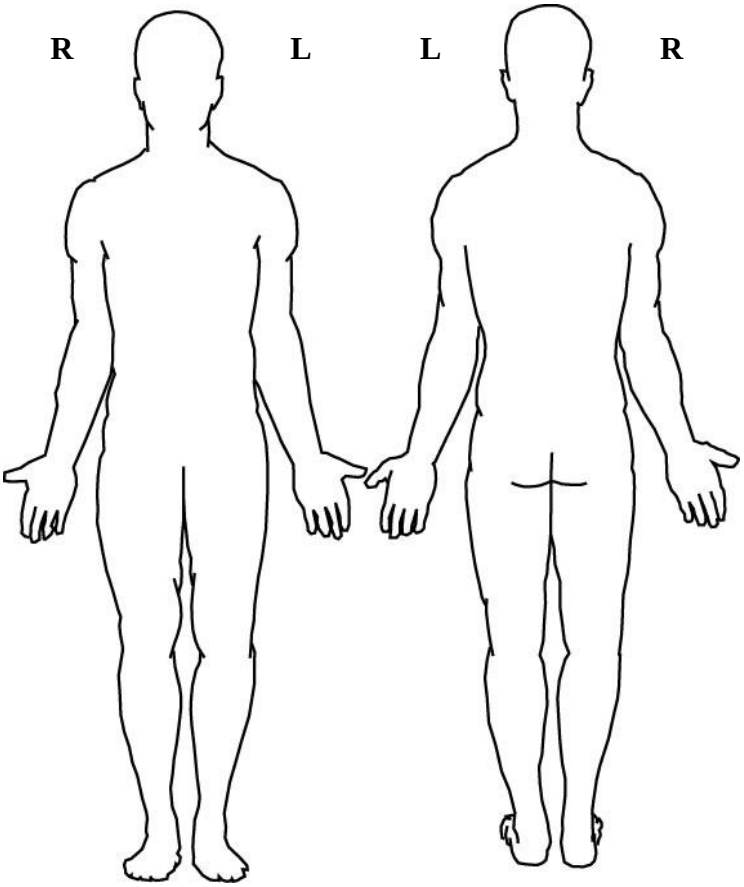
NAME_____ **DATE of BIRTH**_____

CURRENT HEALTH CONCERNS:

Reason(s) for today's visit? _____

How did your symptoms begin? _____

When did your symptoms begin? _____



Instructions:
Please indicate the location and quality of your pain on the body diagram using the key below:

Key:

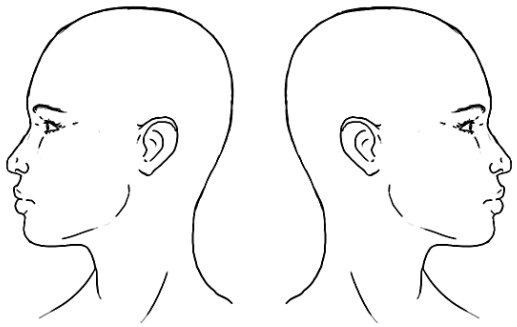
XX – Burning

OO – Stabbing/Sharp

// - Shooting

ZZ – Tingling/Numb

NN – Aching/Nagging



Are your symptoms CONSTANT or INTERMITTENT?

Highest level over the PAST 2 WEEKS: 0 1 2 3 4 5 6 7 8 9 10

Lowest level over the PAST 2 WEEKS: 0 1 2 3 4 5 6 7 8 9 10

What aggravates your symptoms? _____

When are they worst? _____

What relieves your symptoms? _____

When are they best? _____

OTHER TREATMENTS YOU HAVE TRIED:

Type:	Did it help?	Type:	Did it help?

DIAGNOSTIC IMAGING YOU HAVE HAD: e.g. – XRAY, MRI, CTSCAN or OTHER

STUDY	DATE	RESULT	STUDY	DATE	RESULT

YOUR TRAUMA HISTORY:

Motor Vehicle Accidents? Date(s): _____, _____, _____

Concussions? Date(s): _____, _____, _____ Did you lose consciousness? ☐YES ☐NO

Broken Bones? Date(s) & Bone: _____, _____, _____

Significant Falls? Date(s): _____, _____, _____

Any other traumatic events that you believe impacted your health? _____

_____

YOUR MEDICAL HISTORY: **Height_____** **Weight_____**

ILLNESS	Date Diagnosed	ILLNESS	Date diagnosed	ILLNESS	Date diagnosed
☐ Cancer (type)		☐ Asthma		☐ Liver Disease	
☐ Diabetes		☐ Anemia		☐ Ulcers	
☐ Heart Disease		☐ Kidney Disease		☐ Hypothyroid	
☐ High Blood Pressure		☐ Osteoporosis		☐ Hyperthyroid	
☐ High Cholesterol		☐ Tuberculosis		☐ Hepatitis	
☐ Stroke		☐ Rheumatoid Arthritis		☐ Allergies	
☐ Epilepsy		☐ Raynaud's disease		☐ Autoimmune Disease	
☐ Mental Illness		☐ Emphysema		Other:	

HOSPITALIZATIONS or SURGERIES:

Reason/Type	Date	Reason/ Type	Date

CURRENT PRESCRIPTION DRUGS for ANY reason:

Drug Name	Dose	How Often?

SUPPLEMENTS:

Allergies to Medications: _____

Allergies to Food, Environmental or Other Substances: _____

SOCIAL HISTORY:

Do you smoke: ☐ CURRENT ☐ PREVIOUS ☐ NEVER How much: _____

For how long: _____ When did you quit: _____

Do you drink alcohol: ☐YES ☐NO How much/often: _____

Do you use recreational drugs: ☐YES ☐NO Which ones/how much: _____

Do you take any form of caffeine: ☐Coffee ☐Soda ☐Tea ☐Other: _____ How much/often: _____

Do you exercise routinely: ☐YES ☐NO What forms: _____How often: _____

Do you sleep well: ☐YES ☐NO Do you awaken rested: ☐YES ☐NO How many hours per night: _____

How many glasses of water do you drink per day: _____

What is your occupation: _____ Do you enjoy it? ☐YES ☐NO

With whom do you live: _____ Do you enjoy it? ☐YES ☐NO

CURRENT SYMPTOMS: (please check all that apply within the last 6 months)

Constitutional:
☐ Fatigue
☐ Night sweats

Head:
☐ Headaches
☐ Migraines
☐ Dizziness

Neck:
☐ Lumps
☐ Pain or stiffness

Mouth/Throat
☐ Swollen Tongue
☐ Sore Throat
☐ Difficulty swallowing

Cardiovascular:
☐ Heart disease
☐ Heart failure
☐ Heart attack
☐ Chest pain/angina
☐ Fluttering in chest
☐ Heart murmur

Respiratory:
☐ Emphysema
☐ Frequent cough
☐ Bronchitis
☐ Shortness of Breath
☐ Wheezing
☐ Pain on breathing
☐ Pneumonia

Gastrointestinal:
☐ Frequent indigestion
☐ Nausea
☐ Vomiting
☐ Abdominal pain
☐ Heartburn
☐ Hemorrhoids
☐ Constipation
☐ Diarrhea
bowel movements/day: ___
Is this a change? Y N

Urinary:
☐ Pain on urination
☐ Increased frequency
☐ Dribble urine
☐ Frequent infections
☐ Kidney stones

Musculoskeletal:
☐ Joint pain/stiffness
☐ Arthritis
☐ Muscle spasms
☐ Muscle weakness
☐ Loss of coordination
☐ Sprains/Strains

Neurological:
☐ Head injury
☐ Fainting
☐ Paralysis
☐ Numbness/Tingling
☐ Memory loss
☐ Loss taste or smell
☐ Loss of balance

Endocrine:
☐ Heat Intolerance
☐ Cold Intolerance
☐ Excessive Thirst

Hematologic/Lymphatic:
☐ Blood clots
☐ Anemia
☐ Bleeding/bruising
☐ Varicose veins
☐ Cold hands/feet

Emotional
☐ Depression
☐ Sadness
☐ Anxiety
☐ Stress

Male Reproductive
☐ Hernia
☐ Prostate disease
☐ Sexual difficulties
☐ STD's

Female Reproductive
☐ Regular cycles
☐ Sexual difficulties
☐ Pain with intercourse
☐ STD's
☐ Birth Control
What type_____
No. Pregnancies_____
No, live births _____
No. abortions_____

FAMILY HISTORY: (please indicate deceased or alive, medical issues and age)

Father:_____

Mother:_____

Siblings:_____

_____

Grandparents:_____

_____