

Patient History

TESTS: Please list the MOST recent date:

Physical Exam _____ Spinal X-Ray _____ MRI/CT/Bone Scans _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ EKG _____ Urine Test _____

HABITS:

	YES	NO	If yes, please describe:
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day: 0 - 1/2 <input type="checkbox"/> 1/2 - 1 <input type="checkbox"/> 2 or more <input type="checkbox"/> Duration _____
Alcohol Consumption	<input type="checkbox"/>	<input type="checkbox"/>	# Drinks per day _____ Drinks per week _____
Coffee or Tea Consumption	<input type="checkbox"/>	<input type="checkbox"/>	Cups per day _____
Other Drug Use (Street Drugs)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Type _____
Work Activities <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light labor <input type="checkbox"/> Heavy labor			
High Stress <input type="checkbox"/> Y <input type="checkbox"/> N			Sleep Position _____ Number of Hours sleep/night _____

HOBBIES OR INTEREST: _____

MEDICATIONS: Please list all currently used medicines. Include prescription and non-prescription drugs, vitamins, herbs

ALLERGIES: Please list all known allergies, especially to medicines. _____

Treatment you are receiving or have received:

Medical care Chiropractic care Other _____
Name(s) of other doctor(s) who have treated you for this condition _____
What treatment was recommended? _____ Length of time under care? _____ Results? _____

Please mark all that apply:

	Current	Past
History of trauma	<input type="checkbox"/>	<input type="checkbox"/>
Infection	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Unusual fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness / Poor balance	<input type="checkbox"/>	<input type="checkbox"/>
Vomited blood	<input type="checkbox"/>	<input type="checkbox"/>
Bloody or black stools	<input type="checkbox"/>	<input type="checkbox"/>
Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease or murmur	<input type="checkbox"/>	<input type="checkbox"/>
Loss of bowel or bladder control	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness/paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
Severe trauma	<input type="checkbox"/>	<input type="checkbox"/>
Direct head trauma	<input type="checkbox"/>	<input type="checkbox"/>
Lost consciousness	<input type="checkbox"/>	<input type="checkbox"/>
Poor coordination	<input type="checkbox"/>	<input type="checkbox"/>
Night pain	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>

Please mark all that apply:

	Current	Past
Recent infection	<input type="checkbox"/>	<input type="checkbox"/>
History of osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
History of cancer	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Use of corticosteroids	<input type="checkbox"/>	<input type="checkbox"/>
Use of anticoagulants	<input type="checkbox"/>	<input type="checkbox"/>
Use of birth control pills	<input type="checkbox"/>	<input type="checkbox"/>
Numbness in groin (saddle anesthesia)	<input type="checkbox"/>	<input type="checkbox"/>
Loss of anal sphincter tone, fecal incontinence (bowel accidents)	<input type="checkbox"/>	<input type="checkbox"/>
Pain fails to improve with rest	<input type="checkbox"/>	<input type="checkbox"/>
Spinal pain greater than 4 weeks	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged use of corticosteroids	<input type="checkbox"/>	<input type="checkbox"/>
Intravenous drug use	<input type="checkbox"/>	<input type="checkbox"/>
Back pain, stiffness, or weakness	<input type="checkbox"/>	<input type="checkbox"/>
Neck pain, stiffness, or weakness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle spasm in neck or back	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder pain (R / L)	<input type="checkbox"/>	<input type="checkbox"/>
Hip/buttock pain (R / L)	<input type="checkbox"/>	<input type="checkbox"/>
Knee/ankle/foot pain (R / L)	<input type="checkbox"/>	<input type="checkbox"/>
Swollen or painful joints	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or pain in the arms, hands or fingers (R / L)	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or pain in the legs, feet or toes (R / L)	<input type="checkbox"/>	<input type="checkbox"/>

CONDITIONS: Please mark current (C) or past (P) to indicate the following:			
AIDS/HIV	<input type="checkbox"/> C <input type="checkbox"/> P	Diabetes	<input type="checkbox"/> C <input type="checkbox"/> P
Alcoholism	<input type="checkbox"/> C <input type="checkbox"/> P	Emphysema	<input type="checkbox"/> C <input type="checkbox"/> P
Allergy Shots	<input type="checkbox"/> C <input type="checkbox"/> P	Epilepsy	<input type="checkbox"/> C <input type="checkbox"/> P
Anemia	<input type="checkbox"/> C <input type="checkbox"/> P	Fractures	<input type="checkbox"/> C <input type="checkbox"/> P
Anorexia	<input type="checkbox"/> C <input type="checkbox"/> P	Glaucoma	<input type="checkbox"/> C <input type="checkbox"/> P
Appendicitis	<input type="checkbox"/> C <input type="checkbox"/> P	Goiter	<input type="checkbox"/> C <input type="checkbox"/> P
Arthritis	<input type="checkbox"/> C <input type="checkbox"/> P	Gonorrhea	<input type="checkbox"/> C <input type="checkbox"/> P
Asthma	<input type="checkbox"/> C <input type="checkbox"/> P	Gout	<input type="checkbox"/> C <input type="checkbox"/> P
Bleeding Disorders	<input type="checkbox"/> C <input type="checkbox"/> P	Heart Disease	<input type="checkbox"/> C <input type="checkbox"/> P
Breast Lump	<input type="checkbox"/> C <input type="checkbox"/> P	Hepatitis	<input type="checkbox"/> C <input type="checkbox"/> P
Bronchitis	<input type="checkbox"/> C <input type="checkbox"/> P	Hernia	<input type="checkbox"/> C <input type="checkbox"/> P
Bulimia	<input type="checkbox"/> C <input type="checkbox"/> P	Herniated Disc	<input type="checkbox"/> C <input type="checkbox"/> P
Cancer	<input type="checkbox"/> C <input type="checkbox"/> P	Herpes	<input type="checkbox"/> C <input type="checkbox"/> P
Cataracts	<input type="checkbox"/> C <input type="checkbox"/> P	High Cholesterol	<input type="checkbox"/> C <input type="checkbox"/> P
Chemical Dependency	<input type="checkbox"/> C <input type="checkbox"/> P	Kidney Disease	<input type="checkbox"/> C <input type="checkbox"/> P
Chicken Pox	<input type="checkbox"/> C <input type="checkbox"/> P	Liver Disease	<input type="checkbox"/> C <input type="checkbox"/> P
		Measles	<input type="checkbox"/> C <input type="checkbox"/> P
		Migraine Headaches	<input type="checkbox"/> C <input type="checkbox"/> P
		Miscarriage	<input type="checkbox"/> C <input type="checkbox"/> P
		Mononucleosis	<input type="checkbox"/> C <input type="checkbox"/> P
		Multiple Sclerosis	<input type="checkbox"/> C <input type="checkbox"/> P
		Mumps	<input type="checkbox"/> C <input type="checkbox"/> P
		Osteoporosis	<input type="checkbox"/> C <input type="checkbox"/> P
		Pacemaker	<input type="checkbox"/> C <input type="checkbox"/> P
		Parkinson's Disease	<input type="checkbox"/> C <input type="checkbox"/> P
		Pinched Nerve	<input type="checkbox"/> C <input type="checkbox"/> P
		Pneumonia	<input type="checkbox"/> C <input type="checkbox"/> P
		Polio	<input type="checkbox"/> C <input type="checkbox"/> P
		Polyps	<input type="checkbox"/> C <input type="checkbox"/> P
		Prostate Problem	<input type="checkbox"/> C <input type="checkbox"/> P
		Prosthesis	<input type="checkbox"/> C <input type="checkbox"/> P
		Psychiatric Care	<input type="checkbox"/> C <input type="checkbox"/> P
		Rheumatoid Arthritis	<input type="checkbox"/> C <input type="checkbox"/> P
		Rheumatic Fever	<input type="checkbox"/> C <input type="checkbox"/> P
		Scarlet Fever	<input type="checkbox"/> C <input type="checkbox"/> P
		Seizures	<input type="checkbox"/> C <input type="checkbox"/> P
		Stroke	<input type="checkbox"/> C <input type="checkbox"/> P
		Suicide Attempt	<input type="checkbox"/> C <input type="checkbox"/> P
		Thyroid Problems	<input type="checkbox"/> C <input type="checkbox"/> P
		Tonsillitis	<input type="checkbox"/> C <input type="checkbox"/> P
		Tremors	<input type="checkbox"/> C <input type="checkbox"/> P
		Tuberculosis	<input type="checkbox"/> C <input type="checkbox"/> P
		Tumors/Growths	<input type="checkbox"/> C <input type="checkbox"/> P
		Ulcers	<input type="checkbox"/> C <input type="checkbox"/> P
		Vaginal Infections	<input type="checkbox"/> C <input type="checkbox"/> P
		Venereal Disease	<input type="checkbox"/> C <input type="checkbox"/> P
		Whooping Cough	<input type="checkbox"/> C <input type="checkbox"/> P
		Other _____	

GENERAL SYMPTOMS: Please mark current (C) or past (P) to indicate the following:			
GENERAL	GASTROINTESTINAL	EYE EAR NOSE THROAT	MEN only
Bruise easily <input type="checkbox"/> C <input type="checkbox"/> P	Appetite poor <input type="checkbox"/> C <input type="checkbox"/> P	Bleeding gums <input type="checkbox"/> C <input type="checkbox"/> P	Breast lump <input type="checkbox"/> C <input type="checkbox"/> P
Chills <input type="checkbox"/> C <input type="checkbox"/> P	Bloating <input type="checkbox"/> C <input type="checkbox"/> P	Blurred vision <input type="checkbox"/> C <input type="checkbox"/> P	Erection difficulties <input type="checkbox"/> C <input type="checkbox"/> P
Dental problems <input type="checkbox"/> C <input type="checkbox"/> P	Bowel changes <input type="checkbox"/> C <input type="checkbox"/> P	Crossed eyes <input type="checkbox"/> C <input type="checkbox"/> P	Lump in testicles <input type="checkbox"/> C <input type="checkbox"/> P
Depression <input type="checkbox"/> C <input type="checkbox"/> P	Constipation <input type="checkbox"/> C <input type="checkbox"/> P	Difficulty swallowing <input type="checkbox"/> C <input type="checkbox"/> P	Penis discharge <input type="checkbox"/> C <input type="checkbox"/> P
Difficulty sleeping <input type="checkbox"/> C <input type="checkbox"/> P	Diarrhea <input type="checkbox"/> C <input type="checkbox"/> P	Double vision <input type="checkbox"/> C <input type="checkbox"/> P	Sore on penis <input type="checkbox"/> C <input type="checkbox"/> P
Dizziness <input type="checkbox"/> C <input type="checkbox"/> P	Excessive hunger <input type="checkbox"/> C <input type="checkbox"/> P	Earache <input type="checkbox"/> C <input type="checkbox"/> P	Other <input type="checkbox"/> C <input type="checkbox"/> P
Fainting <input type="checkbox"/> C <input type="checkbox"/> P	Excessive thirst <input type="checkbox"/> C <input type="checkbox"/> P	Ear discharge <input type="checkbox"/> C <input type="checkbox"/> P	WOMEN only
Fever <input type="checkbox"/> C <input type="checkbox"/> P	Gas <input type="checkbox"/> C <input type="checkbox"/> P	Hay fever <input type="checkbox"/> C <input type="checkbox"/> P	Abnormal pap smear <input type="checkbox"/> C <input type="checkbox"/> P
Forgetfulness <input type="checkbox"/> C <input type="checkbox"/> P	Hemorrhoids <input type="checkbox"/> C <input type="checkbox"/> P	Hoarseness <input type="checkbox"/> C <input type="checkbox"/> P	Bleeding b/t periods <input type="checkbox"/> C <input type="checkbox"/> P
Headache <input type="checkbox"/> C <input type="checkbox"/> P	Indigestion <input type="checkbox"/> C <input type="checkbox"/> P	Loss of hearing <input type="checkbox"/> C <input type="checkbox"/> P	Breast lump <input type="checkbox"/> C <input type="checkbox"/> P
Loss of sleep <input type="checkbox"/> C <input type="checkbox"/> P	Nausea <input type="checkbox"/> C <input type="checkbox"/> P	Nosebleeds <input type="checkbox"/> C <input type="checkbox"/> P	Extreme menstrual pain <input type="checkbox"/> C <input type="checkbox"/> P
Loss of weight <input type="checkbox"/> C <input type="checkbox"/> P	Rectal bleeding <input type="checkbox"/> C <input type="checkbox"/> P	Persistent cough <input type="checkbox"/> C <input type="checkbox"/> P	Hot flashes <input type="checkbox"/> C <input type="checkbox"/> P
Nervousness <input type="checkbox"/> C <input type="checkbox"/> P	Stomach pain <input type="checkbox"/> C <input type="checkbox"/> P	Ringling in ears <input type="checkbox"/> C <input type="checkbox"/> P	Nipple discharge <input type="checkbox"/> C <input type="checkbox"/> P
Numbness <input type="checkbox"/> C <input type="checkbox"/> P	Vomiting <input type="checkbox"/> C <input type="checkbox"/> P	Sinus problems <input type="checkbox"/> C <input type="checkbox"/> P	Painful intercourse <input type="checkbox"/> C <input type="checkbox"/> P
Sweats <input type="checkbox"/> C <input type="checkbox"/> P	CARDIOVASCULAR	Vision- flashes/halos <input type="checkbox"/> C <input type="checkbox"/> P	Vaginal discharge <input type="checkbox"/> C <input type="checkbox"/> P
Tiredness <input type="checkbox"/> C <input type="checkbox"/> P	Chest pain <input type="checkbox"/> C <input type="checkbox"/> P	SKIN	Other _____
Weight gain <input type="checkbox"/> C <input type="checkbox"/> P	High blood pressure <input type="checkbox"/> C <input type="checkbox"/> P	Bruise easily <input type="checkbox"/> C <input type="checkbox"/> P	Date of last menstrual period _____
GENITOURINARY	Irregular heart beat <input type="checkbox"/> C <input type="checkbox"/> P	Hives <input type="checkbox"/> C <input type="checkbox"/> P	Date of last pap smear _____
Blood in urine <input type="checkbox"/> C <input type="checkbox"/> P	Low blood pressure <input type="checkbox"/> C <input type="checkbox"/> P	Itching <input type="checkbox"/> C <input type="checkbox"/> P	Have you had mammogram? _____
Frequent urination <input type="checkbox"/> C <input type="checkbox"/> P	Poor circulation <input type="checkbox"/> C <input type="checkbox"/> P	Change in moles <input type="checkbox"/> C <input type="checkbox"/> P	Are you pregnant? _____
Lack of bladder control <input type="checkbox"/> C <input type="checkbox"/> P	Rapid heart beat <input type="checkbox"/> C <input type="checkbox"/> P	Rash <input type="checkbox"/> C <input type="checkbox"/> P	Number of children _____
Painful urination <input type="checkbox"/> C <input type="checkbox"/> P	Swelling of ankles <input type="checkbox"/> C <input type="checkbox"/> P	Scars <input type="checkbox"/> C <input type="checkbox"/> P	
Bladder infection <input type="checkbox"/> C <input type="checkbox"/> P	Varicose veins <input type="checkbox"/> C <input type="checkbox"/> P	Sore that won't heal <input type="checkbox"/> C <input type="checkbox"/> P	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Name, Printed _____

Patient Signature _____

Date _____

Doctor Signature _____

Date _____

ABOUT YOUR FAMILY HISTORY:

Please mark relative's current age or age at time of death, place an X in the boxes that apply to them. Describe "Other" and list cause of death

	Age	Allergy - Asthma	Alcohol Abuse	Arthritis - Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or back disorder	Stroke	Tuberculosis	Chronic Pain	Other	If deceased, cause of death
Mother's Mother																				
Mother's Father																				
Father's Mother																				
Father's Father																				
Father																				
Mother																				
Brother's & Sisters #1																				
#2																				
#3																				
#4																				
#5																				
Spouse																				
Children #1																				
#2																				
#3																				
#4																				
#5																				

AREAS INVOLVED INDICATE

HOSPITALIZATIONS, OPERATIONS, AUTO & ON THE JOB INJURIES

EVALUATIONS & TREATMENT

(Please be as specific as possible)

Year

1. _____
2. _____
3. _____
4. _____
5. _____

SERIOUS ILLNESSES: List current and past illnesses not mentioned above. (Including cancer, diabetes, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____

Patient Name, Printed _____

Patient Signature _____

Date _____

Doctor Signature _____

Date _____

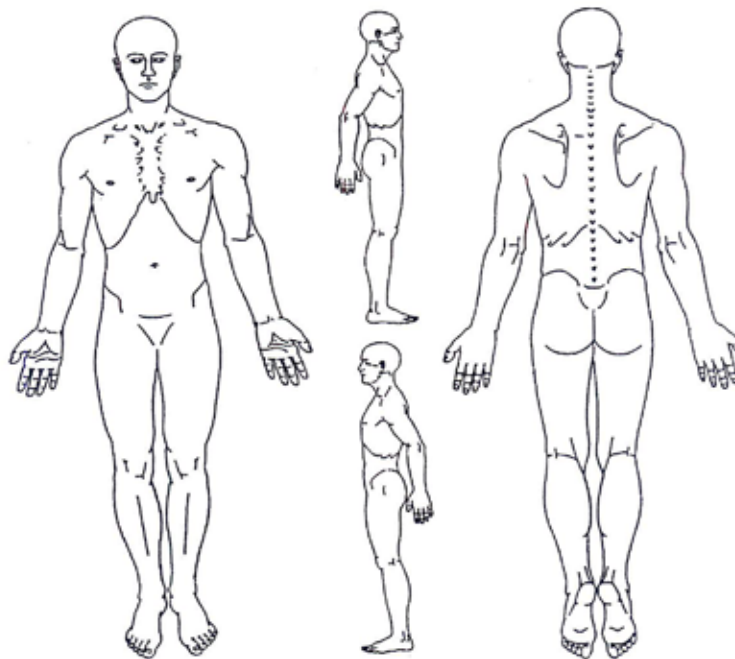
Pain Location, Intensity & Frequency Questionnaire

Reason for Visit: _____
 Other Concerns/Symptoms: _____
 Comments: _____
 When did your symptoms appear? _____
 Have you had similar symptoms in the past? Y N When? _____

Please use the codes below to explain and locate the areas that are bothering you.

Key

<i>Use letters below to indicate type and location of discomfort</i>		
A = ACHE	B = BURNING	S = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER



**Please rate the Intensity & Frequency of your pain using 0 – 10 Pain scale
 (0=No pain, 10=Most severe imaginable)**

Present pain level __; Average pain level __; pain present __% of the time;
 Worst pain level __, present __% of the time; lowest pain level __, present __% of time.
 What will increase your pain? _____
 What gives you the greatest relief/contol of pain? _____
 Is this condition getting progressively worse? Y N Unknown
 Symptoms present in Morning Afternoon Evening Night Constant
 What are you unable to do because of your pain? _____
 What are your goals for this visit? _____

Patient Name, Printed _____ Date _____
 Patient Signature _____ Doctor Signature _____