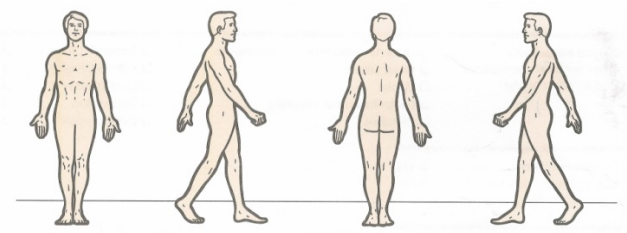
Patient: _____ Date: _____

Reason for today's visit:
Since your symptoms began are you: ❒ better ❒ no change ❒ worse
How long have you had these symptoms?
Are your symptoms: ❒ intermittent ❒ constant
Please mark: "P" for pain "X" for intense pain "N" for numbness



Describe your symptoms:

What makes you better?

What makes you worse?

Rate today's level of pain: (0= no pain, 10=worst pain ever/I need to go to the hospital)
0 1 2 3 4 5 6 7 8 9 10
Rate your worst level of pain: (0= no pain, 10=worst pain ever/I need to go to the hospital)
0 1 2 3 4 5 6 7 8 9 10
Rate your lowest level of pain: (0= no pain, 10=worst pain ever/I need to go to the hospital)
0 1 2 3 4 5 6 7 8 9 10

Do you have:
Weakness? ❒ Yes ❒ No If yes, where:
Numbness? ❒ Yes ❒ No If yes, where:

Please list all diagnostic tests you have had for this condition: (MRI, CT Scans, X-rays, or EMG)

Please list all the treatments you have had for this condition: (Physical Therapy, Spinal Injections, Trigger Point Injections, Joint Injections, or Surgery)

Pleas list all physicians, chiropractors, surgeons and providers you have seen for this condition:

Daily and Work activities (check all that apply):

Daily Care: ❒ I can do all of the following: ❒ Wash, Bathe, and Dress self ❒ Drive a car ❒ Ride in car ❒ Do Yard work

Work: ❒Working ❒Working with Restrictions ❒Permanently Disabled ❒Retired ❒Temporarily Disabled ❒ In School

Please give job title:

Which is your dominant hand? ❒ right ❒ left

Have you had Physical Therapy: ❒ Yes ❒ No

Did it help? ❒ Yes ❒ No

Do you perform a Home Exercise Program? ❒ Yes ❒ No

If you have a TENS unit, does it help? ❒ Yes ❒ No

List **only** medicines you are taking for this complaint and how you take them: Does it help?

❒ Yes ❒ No

❒ Yes ❒ No

❒ Yes ❒ No

❒ Yes ❒ No

List medications you have tried for this condition or complaint in the past:

List any other medications you are currently taking:

Review of systems

Please check those you have. Leaving blank indicates no new symptoms.

Constitutional	❒ weight loss	❒ weight gain	❒ fever	❒overall weakness	❒ fatigue
Skin	❒ dry	❒ rash	❒ itch	❒ change in color	❒ change in nails
Blood/Lymph	❒ swollen gland	❒ easy bleeding	❒ anemia easy bruising	❒ blood clot	
Eyes	❒ redness	❒ tearing	❒ change in vision		
ENT	❒ runny nose	❒ stuffy head	❒ hearing change	❒ difficulty swallowing	❒ change in taste
CV	❒ chest pain	❒ racing heart	❒ swelling		
Respiratory	❒ cough	❒ wheezing	❒ shortness of breath		
GI	❒ stomach pain	❒ constipation	❒ diarrhea	❒ blood in stool	❒ nausea/vomiting
GU	❒ blood in urine	❒ burning with urination	❒ loss of bladder control		
Neurologic	❒ numbness	❒ weakness	❒ dizziness	❒ change in memory	❒ headache
Psychiatric	❒ depressed	❒ anxious	❒ anger	❒ moody	❒ argumentive
Endocrine	❒ increased thirst	❒ enlarged thyroid	❒ high blood sugar	❒ low blood sugar	
Allergy	❒ hay fever	❒ new allergic reaction	❒ new immune problem		
Muscle/Bone	❒ joint swelling	❒ stiffness	❒ muscle pain	❒ new broken bone	

Patient Signature:_____ Date:_____

Staff Initials: Provider initials:

Name: _____

Allergies: _____ ❒ No Known Allergies

Past Medical History
Please check any of the following medical conditions you have or have had:

❒ diabetes	❒ heart attack/angina	❒ heart failure	❒ stomach ulcers
❒ seizures	❒ arthritis	❒ hepatitis	❒ HIV/AIDS
❒ asthma	❒ breathing problems	❒ anxiety	❒ depression
❒ alcoholism	❒ easy bleeding	❒ drug abuse	❒ nervous breakdown
❒ headache	❒ motor vehicle accident	❒ kidney	❒ worker injury
❒ high blood pressure	❒stroke	❒fibromyalgia	❒ colitis

❒gastritis
❒cancer, please list type:
❒ other medical conditions, please list:

Surgical History
Please check the surgeries you have had:

❒ heart bypass	❒ appendectomy	❒ gall bladder	❒ tonsillectomy	❒ hysterectomy
❒ ovary	❒ carpal tunnel	❒ joint surgery	❒ neck surgery	❒ back surgery
❒ kidney	❒ cardiac stents	❒ Greenfield filter	❒ pacemaker/defibrillator	
❒ spinal cord stimulator	❒ other surgeries, please list:			

Injury History
Please check previous injuries you have had prior to this visit:

❒ neck ❒ back ❒ head ❒ broken bone ❒ car accident

Family History
Please check any illnesses that other family/blood relatives have had:

❒ diabetes	❒ heart disease	❒ stroke	❒ arthritis	❒ alcoholism
❒ drug abuse	❒ cancer, please list type:			

Social History
Do you use: ❒ none ❒ cigarettes ❒ cigars ❒ snuff ❒ chew ❒ pipe How often and how much:

Do you drink: ❒ none ❒ beer ❒ liquor ❒ wine How often and how much:

Do you use: ❒ none ❒ cocaine ❒ speed ❒ PCP ❒ marijuana/pot ❒ other illicit drugs

Have you had any accusations or convictions for illegal drugs or alcohol? ❒ Yes ❒ No
Have you had any treatment for drug, alcohol or substance abuse or misuse? ❒ Yes ❒ No

What is the last grade of education or school completed? _____

Please list any hobbies:

Patient signature: _____ Date: _____

Staff initials: _____