Name:_____**DOB**:_____**Date**:_____

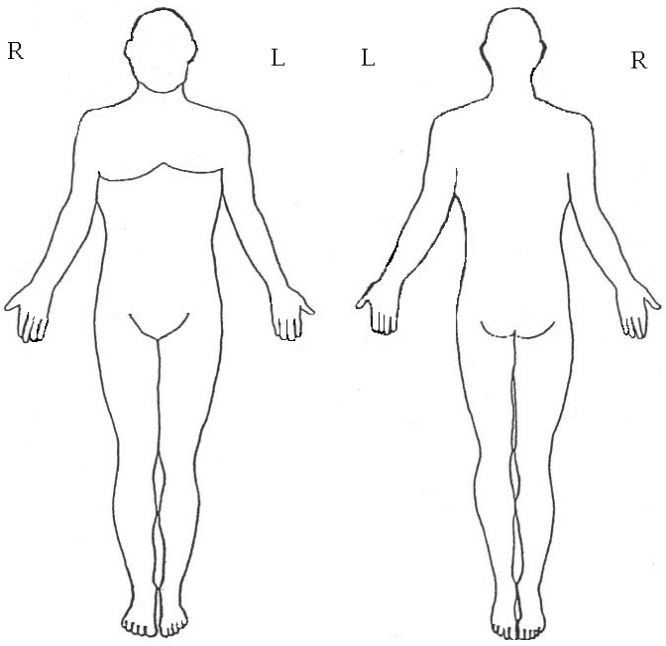
Chief Complaint (reason for visit): _____

_____

History of Present Illness:

- How long have you had these symptoms? _____
- Explain how this illness or injury occurred, if applicable: _____

  _____
- How severe is the pain, on a scale of 1-10? ____Describe:_____Constant/intermittent
- Any weakness? _____ Numbness or tingling? _____
- What relieves the pain/symptoms? _____
- What makes the pain/symptoms worse? _____
- Any similar symptoms in the past? _____



- **Use the drawing to illustrate your symptoms. Indicate pain, numbness, or both.**
- List any doctors you have seen for this condition and any treatment, medications, or recommendations given:

  _____

  _____

  _____
- Please list any physical therapy, chiropractic treatments, or injections. Include dates and results.
- _____

  _____

  _____

Past Medical History: (Please check/circle all appropriate medical conditions; explain if necessary)

____ Heart problems: CAD, MI, CHF, Afib, other/specify:_____
____ Lung problem: COPD, asthma, sleep apnea, other:_____
_____High blood pressure
____ Blood clotting disorder
____ Diabetes ____ Kidney disease
____ Stroke or TIA ____ Thyroid disease
____ Vascular disease ____ High Cholesterol
____ Arthritis ____ Gout
____ Neuropathy ____ Seizures/Epilepsy
____ Cancer:_____

_____Psychological: depression, anxiety, bipolar, PTSD, ADD, ADHD, other:_____
____ Migraines or other chronic headaches
____ Osteoporosis or osteopenia
____ Acid reflux, ulcers, or stomach problems
____ Hepatitis, cirrhosis, or other liver disease
____ Deficient immune system ____ HIV/AIDS
____Autoimmune disease: Rheumatoid arthritis, lupus, other:_____
____ Other: _____
_____

Name:_____ **DOB**:_____**Date**:_____

Surgical and Other Medical History: (Please list all previous surgeries and hospitalizations)

_____

_____

_____

Medications (Please list all current medications and their dosage; include herbals and supplements):
If you have a list, please provide to us and we will copy.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

Are you in a medication contract with a pain management or other physician? Y N

Medication Allergies:

Medication	Reaction
_____	_____
_____	_____
_____	_____

Social History:

- Occupation: _____ Marital Status: _____
- Tobacco use: None_____ Current or previous tobacco use (specify):_____
- Alcohol use: Never_____ Rarely_____ Moderate_____ Daily_____
- Illegal/"Street" Drug use None_____ Type/Frequency_____
- History of alcohol or drug abuse problems? Y N

Family Medical History:

	Age	Diseases	Cause of death, if applicable
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Name:_____ **DOB**:_____**Date**:_____

Review of Symptoms (please specify if applicable):

Constitutional		
Weight gain	N	Y
Weight loss	N	Y
Fatigue	N	Y
Poor appetite	N	Y
Fevers	N	Y
Chills	N	Y
Night sweats	N	Y
Eyes		
Blurry vision	N	Y
Double vision	N	Y
Blind spot(s)	N	Y
Cataracts	N	Y
Glaucoma	N	Y
Other eye disease (specify)	N	Y
ENT		
Hearing loss	N	Y
Ringing in ears	N	Y
Earaches	N	Y
Ear drainage	N	Y
Sinus problems	N	Y
Hayfever/seasonal allergies	N	Y
Nose bleeds	N	Y
Hoarseness/voice change	N	Y
Cardiovascular		
Chest pain	N	Y
Palpitations	N	Y
Swelling of feet, ankles	N	Y
Poor circulation	N	Y
Respiratory		
Shortness of breath	N	Y
when lying flat	N	Y
Frequent cough	N	Y
dry	N	Y
productive	N	Y
GI		
Ulcers	N	Y
Heartburn/acid reflux	N	Y
Constipation	N	Y
Frequent diarrhea	N	Y
Nausea/vomiting	N	Y
Blood in stool	N	Y
Abdominal pain	N	Y
Hemorrhoids	N	Y
Difficulty swallowing	N	Y
Painful swallowing	N	Y
GU		
Frequent urination	N	Y
Burning with urination	N	Y
Blood in urine	N	Y
Incontinence	N	Y
Kidney stones	N	Y
Sexual difficulties	N	Y
(Male) Prostate problems	N	Y

(Female)Painful periods	N	Y
Irregular periods	N	Y
Pregnancies:_____		
Miscarriages:_____		
Last period:_____		
Musculoskeletal		
Neck pain	N	Y
Back pain	N	Y
Joint pain	N	Y
Joint stiffness	N	Y
Muscle weakness	N	Y
Muscle spasms	N	Y
Integument		
Skin problems	N	Y
Change in hair or nails	N	Y
Varicose veins	N	Y
Excessive sweating	N	Y
Breast pain	N	Y
Breast discharge	N	Y
Neurological		
Dizziness	N	Y
Lightheadedness	N	Y
Seizures	N	Y
Spasticity (limb stiffness)	N	Y
Tremors	N	Y
Numbness/tingling	N	Y
Paralysis	N	Y
Head injury	N	Y
Psychiatric		
Memory loss/confusion	N	Y
Depression	N	Y
Anxiety	N	Y
Insomnia	N	Y
Delusions or hallucinations	N	Y
Mood swings		
Endocrine		
Hormone problems	N	Y
Excessive thirst	N	Y
Excessive appetite	N	Y
Change in hat or glove size	N	Y
Heme/Lymph/Immune System		
Easy bruising	N	Y
Excessive bleeding	N	Y
Slow or poor wound healing	N	Y
Anemia	N	Y
Enlarged glands/lymph nodes	N	Y
Previous blood transfusion	N	Y
Frequent or serious infections	N	Y
HIV or AIDS	N	Y
Current daily steroid or other immunosuppressant	N	Y
Current chemotherapy	N	Y

_____ _____

Patient Signature Provider Signature