

Date _____

Patient's Name _____

Patient's Address _____ City _____ State _____ Zip Code _____

Age _____ D.O.B. _____ Single Married Divorced Widowed No. of Children _____

Occupation _____ Employer _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Mate's Name _____ Mate's DOB _____

Please list your family physician. _____

May we have permission to contact them? Yes No

Emergency Contact _____ Relationship _____ Contact Phone _____

Who referred you? _____ Date of last physical exam _____

What is the reason for today's appointment?

Primary condition: _____

Condition 1: _____

Condition 2: _____

Are all the above condition(s) due to an Auto Accident? Yes No or Work-Related Injury? Yes No

Condition(s) began when and how? _____

What is the Quality of the complaints/pain? dull aching sharp shooting burning throbbing

deep nagging Other _____

Does this condition/pain radiate or travel (shoot) to any other areas of body? Yes No Where? _____

Do you have numbness or tingling in your body? Yes No Where? _____

Grade Intensity/Sensitivity 0 1 2 3 4 5 6 7 8 9 10

(Where "0" is No complaint/pain and "10" is Worst complaint/pain imaginable)

How frequent are condition(s) present, and how long does it last? _____

Does anything aggravate the condition(s)? Yes No Describe _____

Does anything make the condition(s) better? Yes No Describe _____

Describe interventions, treatments, medications, surgery or care that you've sought for your condition:

Past Health History

Previous Illnesses: _____

Previous Injury/Trauma: _____

Broken Bones? Which? _____

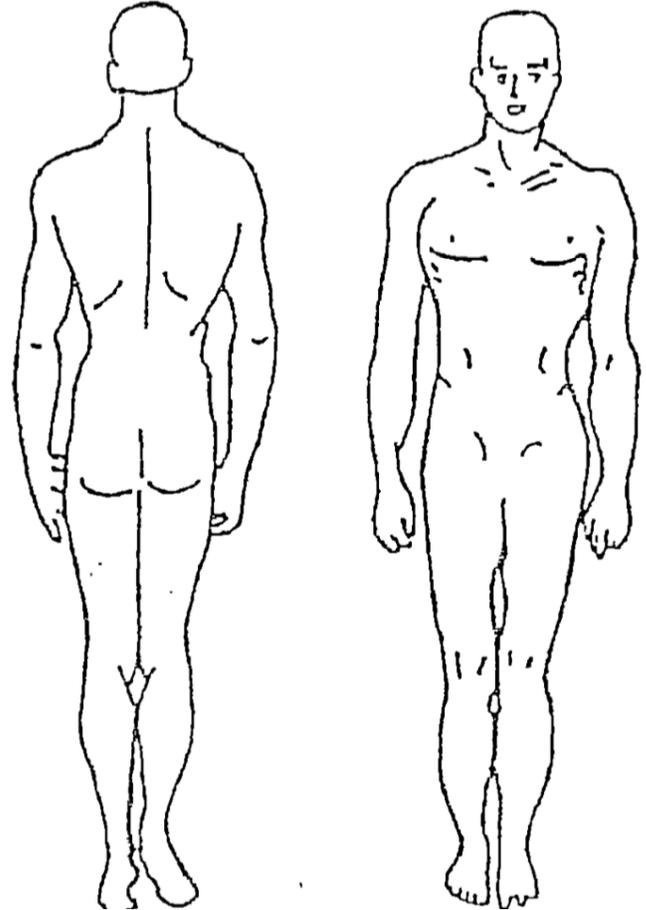
Allergies: _____

Initials _____

If you have had the following, or still suffer from the following, Please Check below...

| Conditions, Symptom or Problem | Constantly or Frequently | Sometimes or Occasionally |
|--------------------------------|--------------------------|---------------------------|
| Headache | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraines | <input type="checkbox"/> | <input type="checkbox"/> |
| Neck Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Shoulder Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Arm/Hand Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Mid-Back Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Low-Back Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Hip Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg/Foot Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Disc Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Joint Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Swelling | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| Nausea | <input type="checkbox"/> | <input type="checkbox"/> |
| Weakness | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervousness | <input type="checkbox"/> | <input type="checkbox"/> |
| Insomnia | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent Colds | <input type="checkbox"/> | <input type="checkbox"/> |
| Nose Bleeds | <input type="checkbox"/> | <input type="checkbox"/> |
| Ringing in Ears | <input type="checkbox"/> | <input type="checkbox"/> |
| Earaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Cough | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Female Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Digestive Problem | <input type="checkbox"/> | <input type="checkbox"/> |
| Urinary Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin Conditions | <input type="checkbox"/> | <input type="checkbox"/> |

Circle the areas where you have any problems. Please describe these problems.



Please fill in below, any other health information you feel that we might need for your wellbeing and care.

Thank you for being complete and thorough.

Please sign below

Today's Date _____

List **current medications**, followed by your reason for taking each:

- | | |
|----------|--------------|
| 1. _____ | Reason _____ |
| 2. _____ | Reason _____ |
| 3. _____ | Reason _____ |
| 4. _____ | Reason _____ |

List any **prior surgeries/medical procedures**, along with the date:

- | | |
|----------|------------|
| 1. _____ | Date _____ |
| 2. _____ | Date _____ |
| 3. _____ | Date _____ |
| 4. _____ | Date _____ |

For Females only:

What was the date of your last menstrual period? _____

Are you pregnant now? Yes No

Lifestyle

- | | | | | |
|---------------------------------|----------------------------------|--|------------------------------------|--------------------------------|
| How often do you exercise? | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| How often do you drink alcohol? | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| How often do you smoke? | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| Do you use recreational drugs? | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| How is your diet? | <input type="checkbox"/> Healthy | <input type="checkbox"/> Healthy Sometimes | <input type="checkbox"/> Fast Food | |

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Person responsible for payment _____