Patient Name:_____ **Today's Date:** _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office:

Primary or Chief Complaint: _____

When did the problem(s) begin? _____

How did the injury happen? _____

How often do you experience you symptoms?

- ☐ Constant (76-100% of the day)
- ☐ Frequent (51-75% of the day)
- ☐ Occasional (26-50% of the day)
- ☐ Intermittent (0-25% of the day)

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaint by circling the number:
Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Secondary: _____

When did the problem(s) begin? _____

How did the injury happen? _____

How often do you experience you symptoms?

- ☐ Constant (76-100% of the day)
- ☐ Frequent (51-75% of the day)
- ☐ Occasional (26-50% of the day)
- ☐ Intermittent (0-25% of the day)

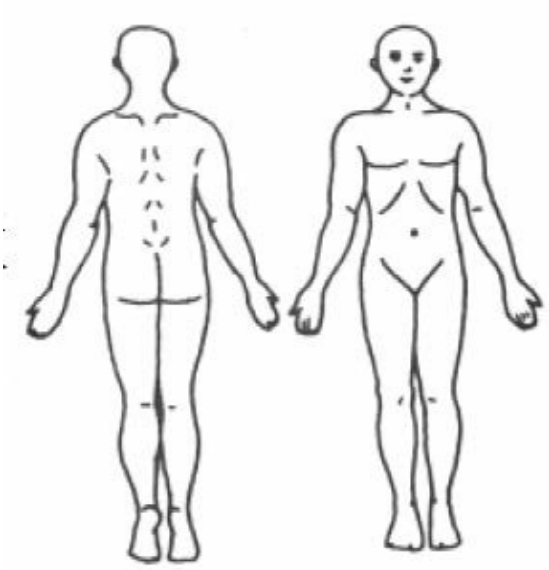
On a scale of 1 to10 with 10 being the worst pain and zero being no pain,rate your above complaint by circling the number:
Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Additional Complaint(s): _____

_____

_____

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing
T = Tingling



What relieves your symptoms? _____

_____

What makes your symptoms feel worse? _____

_____

Continue on next page

Patient Name: _____ **Today's Date:**_____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when?_____ by whom? _____

How long were you under care? _____ What were the results? _____

List Prescription & Non-Prescription drugs/supplements you take:

_____

_____

_____

PLEASE identify ALL PAST and any **CURRENT** conditions:

	BODY PART	HOW LONG AGO
INJURIES	→	
SURGERIES	→	
CHILDHOOD DISEASES	→	
ADULT DISEASES	→	

SOCIAL HISTORY

1. Tobacco: ☐cigars ☐pipe ☐cigarettes ☐chew How often? ☐ Daily ☐ Weekends ☐Occasionally ☐Never

2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐Occasionally ☐Never

3. Recreational Drug use: ☐ Daily ☐ Weekends ☐Occasionally ☐Never

4. Caffeine: ☐ Daily ☐ Weekends ☐Occasionally ☐Never

Continue on next page

Patient Name: _____ Today's Date: _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life. Please only select one effect per activity.

ACTIVITIES:	EFFECT: Please select only one per activity		
Carry Objects	☐ No Effect	☐ Painful	☐ Unable to Perform
Lift Objects	☐ No Effect	☐ Painful	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful	☐ Unable to Perform
Computer Use/Read	☐ No Effect	☐ Painful	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful	☐ Unable to Perform
Personal Care	☐ No Effect	☐ Painful	☐ Unable to Perform
House Work	☐ No Effect	☐ Painful	☐ Unable to Perform

Other _____

_____

What activities or movements would you like to be able to perform, that you feel unable to do because of your symptoms? _____

_____

_____

What are your goals with treatment? _____

_____

_____

Continue on next page

Please review the following list of medical problems and mark all that apply to you. Please review carefully. Medical conditions that do not seem related to your current situation could result in a serious complication if you do not let us know.

Constitutional
- ☐ Recent change in weight
- ☐ Fatigue
- ☐ Weakness of arm/leg
- ☐ Numbness of arm/leg
- ☐ Headaches/Migraines
- ☐ Loss of consciousness
- ☐ Sinus problems
- ☐ Hay fever allergies
- ☐ Difficulty hearing
- ☐ Difficulty swallowing

Cardiovascular/ Respiratory
- ☐ Heart murmur/irregular heart beat
- ☐ Heart pacemaker/defibrillator
- ☐ Chest pain or angina with exertion
- ☐ Heart disease
- ☐ Swelling in feet or ankles
- ☐ Shortness of breath
- ☐ Bleeding disorders
- ☐ Blood clots
- ☐ High blood pressure
- ☐ Asthma

Gastrointestinal
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Difficulty with bowel/bladder function

Musculoskeletal
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Herniated disc
- ☐ Pinched nerve

Integumentary/Dermatologic
- ☐ Skin rash or sores

Neurologic
- ☐ Seizures or convulsions
- ☐ Stroke
- ☐ Brain aneurysm or hemorrhage
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Muscular dystrophy

Psychiatric
- ☐ Depression
- ☐ Anxiety or panic attacks
- ☐ Psychiatric care
- ☐ Suicide attempt

Endocrine
- ☐ Diabetes Type ☐ I or ☐ II
- ☐ Thyroid conditions
- ☐ Goiter
- ☐ Steroid use

Lymphatic
- ☐ Swollen glands or masses
- ☐ Breast lump
- ☐ Lymphedema

Allergies

_____

_____

Illness / Disease
- ☐ Chicken pox
- ☐ Gout

Other
- ☐ Alcoholism
- ☐ Appendicitis
- ☐ Cancer: Type_____
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Tumor or growth
- ☐ Venereal disease
- ☐ Other _____

For women only

Are you pregnant Yes No
Are your menstrual cycles regular Yes No
Date of last menstruation _____

For men only
- ☐ Testicular pain
- ☐ Prostate condition

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes
If yes whom? ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ son(s) ☐ daughter(s)
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes:_____

Patient Name:_____

Patient Signature:_____ Today's Date: ___/___/____

_____
Provider's Signature

____/____/____
Date Form Reviewed