Date: ____/____/____ Referring Physician:_____

Name: _____ Date of Birth: ____/____/____ Age:_____

Home town: _____ Right / Left Handed

Reason for visit:_____

_____

_____

Other physicians / chiropractors seen for this symptom: _____

_____

Past Tests: ❑ CT Scan ❑ MRI ❑ EEG ❑ EMG ❑ X-rays ❑ Ultrasound / Doppler

Past Medical History: Have you ever had any of the following *(check all that apply)*

❑ Anemia
❑ Easy bleeding or bruising
❑ Cancer, type:_____
❑ Asthma
❑ Pneumonia
❑ Heart Attack / Coronary Artery Disease
❑ Congestive Heart Failure
❑ High Blood Pressure
❑ Peripheral Vascular Disease
❑ Blood Clots
❑ Stroke
❑ Depression
❑ Psychiatric illness
❑ Hepatitis
❑ Kidney Disease, type:_____
❑ Seizures
❑ Stomach problems - ulcer / reflux
❑ Urinary Tract Infections
❑ Diabetes - insulin / oral / diet
❑ Gout
❑ Thyroid Disease
❑ Arthritis
❑ Bursitis
❑ Back Pain/ Neck Pain
❑ Headaches
❑ Other_____
❑ Other_____

Past Surgical History: *(check all that apply)*

❑ back/spine surgery: laminectomy / fusion / discectomy _____

❑ cholecystectomy / gallbladder ❑ appendectomy ❑ tonsillectomy ❑ hysterectomy ❑ hernia repair

❑ pacemaker ❑ cardiac bypass ❑ cataract surgery ❑ other: _____

Current Medications: (name and dose) Pharmacy:_____ Phone: _____

1) _____ 6)_____

2) _____ 7)_____

3) _____ 8)_____

4) _____ 9)_____

5) _____ 10)_____

Allergies: ❑ None known ❑ Yes:_____

Family History: *(list health problems of family members)*

Father:_____ deceased, _____age/living,_____age

Mother: _____ deceased, _____age/living,_____age

Brother(s): #_____ _____

Sister(s): #_____ _____

Your children: #_____ _____

Social History:

M / D / S / W Occupation:_____

Tobacco: present past how much:_____ how long:_____ when quit: _____

Alcohol: present past how much:_____ how long: _____

Caffeine: present past coffee:_____/day pop:_____/day

Illicit Drugs: present past_____

Exercise: ❑ Yes ❑ No How much:_____Type:_____

Diet: ❑ Regular ❑ Special:_____

Review of Systems: **Have you experienced any of the following in the last 6 months** *(circle all that apply)*

General: fatigue, weight loss, weight gain, fever, sleep problems, change in appetite

Skin: rashes, itching, lesions, hair loss

Eyes: pain, discharge, eye disease or injury, blurred vision, double vision, wear glasses / contacts

ENT: hearing loss, tinnitus (ringing in ears), earaches or drainage, sinus problems, nose bleeds, mouth sores, bleeding or swollen gums, sore throat or voice change

Respiratory: cough, shortness of breath, asthma or wheezing

Cardiovascular: chest pain, palpitations, heart murmur, sudden heart beat changes, swelling in legs (edema)

GI: stomach pain, heartburn, nausea or vomiting, diarrhea, constipation, blood in stools

GU: urinary retention, incontinence or dribbling, trouble with urination, frequent urination, burning or painful urination, blood in urine, kidney stones, frequent urination at night

Musculoskeletal: joint pain, joint stiffness, swollen joints, muscle pain or cramps, loss of strength, difficulty in walking

Neurologic: frequent or recurring headaches, dizziness, gait disturbance, coordination loss, speech difficulty, seizures, tremors, numbness or tingling sensations, stroke

Psych: anxiety, depression, excessive stress, memory loss or confusion

Endocrine: thyroid disease, excessive thirst or urination, heat or cold intolerance, dry skin, change in hat or glove size

Women Only:

Are you post menopausal: ❑ Yes ❑ No

If not, is it a possibility you are pregnant: ❑ Yes ❑ No

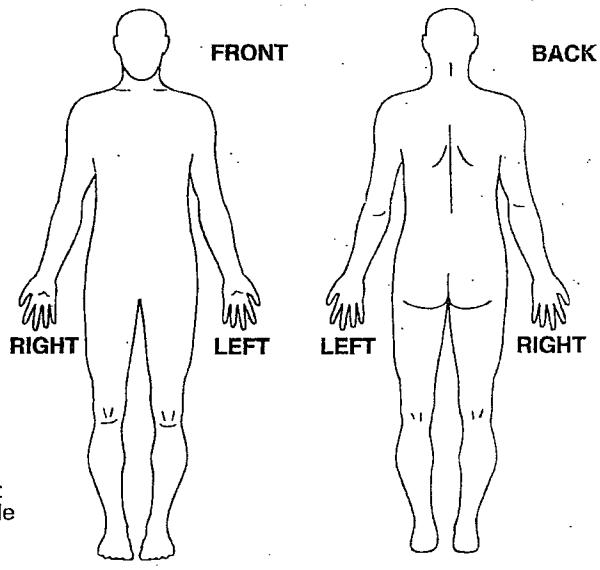
Are you lactating: ❑ Yes ❑ No

Pain Screening and Assessment:

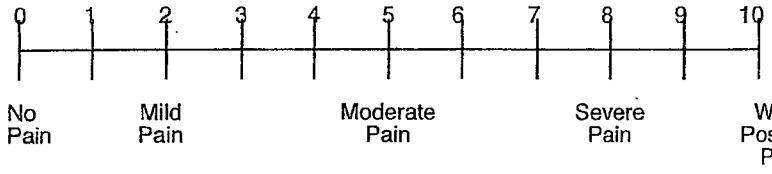
Do you have pain now: ❑ Yes ❑ No

Did you have pain in the last week/month: ❑ Yes ❑ No

Circle where your pain is now:



Where do you rate your pain in the pain scale below?



Ability to function: ❑ excellent ❑ good ❑ fair ❑ poor

If fair or poor, please explain:_____

Psychosocial History:

Support services available: ❑ Family ❑ Friends ❑ Social Services ❑ Government Agencies ❑ Home Health Care ❑ Other:_____

Housing: ❑ Alone ❑ With family (#_____) ❑ House ❑ Apartment

Advanced Directives:

Do you have any Advanced Directives, e.g. Living Wills, Durable Power of Attorney: ❑ Yes ❑ No

Please provide us with a copy for your medical records.

Are current symptoms due to a work related injury or other accident: ❑ Yes ❑ No

If yes, any litigations planned:_____ Date of injury:_____

Patient Signature: _____ Date: ____/____/____

Nurse / Reviewer Signature: _____ Date: ____/____/____

Updated: Date: ____/____/____ ❑ No change ❑ Change ❑ Initials_____

Date: ____/____/____ ❑ No change ❑ Change ❑ Initials_____