PATIENT CONDITION

Fill in all the information to the best of your knowledge

Reason for visit

_____

When did the symptoms start?

_____

How did your problem start?

_____

Rate your level of pain today:

○ No Pain - 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 - Severe Pain

Is Your Condition:

○ Getting Better ○ Staying the Same ○ Getting Worse

Is your pain:

○ Constant (100% of the day) ○ Occasional (50%) ○ Frequent (75%) ○ Intermittent (25%)

Describe the pain:

☐ **Sharp** ☐ **Stabbing** ☐ **Burning** ☐ **Dull Ache** ☐ **Throbbing** ☐ **Shooting** ☐ **Numbing** ☐ **Tingling**

Does it interfere with:

☐ **Work** ☐ **Daily Activity** ☐ **Sleep** ☐ **Recreation** ☐ **Nothing**

What makes you worse:

☐ **Sitting** ☐ **Standing** ☐ **Walking** ☐ **Bending** ☐ **Lying Down**

What makes you better:

☐ **Nothing** ☐ **Rest** ☐ **Activity** ☐ **Heat** ☐ **Cold** ☐ **Medication**

What test have you had:

☐ **X-Rays** ☐ **MRI** ☐ **EMG** ☐ **Ultrasound** ☐ **Lab work**

What treatment have you had:

☐ **Drugs** ☐ **Physical Therapy** ☐ **Surgery** ☐ **Nerve Blocks**

Has the treatment helped?

○ Yes ○ No

Have you ever had this problem before?

○ Yes ○ No

SOCIAL HISTORY

Marital Status _____

Patient Smoking Status _____

Patient Smoking Frequency _____

Use of Alcohol:

◯ Never ◯ Rarely ◯ Moderate ◯ Daily

Work Activity:

◯ Light Labor ◯ Heavy Labor ◯ Sitting ◯ Standing

Exercise Activity:

◯ None ◯ Light ◯ Moderate ◯ Strenuous

FAMILY HISTORY

Father Living?

◯ Yes ◯ No

Mother Living?

◯ Yes ◯ No

Sibling(s) Living?

◯ Yes ◯ No

Father's Health History:

- ☐ Rheumatoid Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Back Problems

Mother's Health History:

- ☐ Rheumatoid Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Back Problems

Sibling(s) Health History:

- ☐ Rheumatoid Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Back Problems

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

(Check all that apply to you)

Cardiovascular:

- [ ] Chest Pain/Palpitations
- [ ] Dizziness/Fainting
- [ ] Shortness of Breath
- [ ] Heart Attack
- [ ] Swelling in Hands/Feet
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Congestive Heart Failure

Gastrointestinal:

- [ ] Heartburn
- [ ] Nausea/Vomiting
- [ ] Diarrhea/Constipation
- [ ] Blood in Stools
- [ ] Gall Bladder Problems
- [ ] Liver Problems
- [ ] Ulcers

Ear, Nose, Throat:

- [ ] Hard of Hearing
- [ ] RInging in Ears
- [ ] Vertigo
- [ ] Sinus Problems
- [ ] Nose Bleeds
- [ ] Sore Throat/Voice Change
- [ ] Swollen Glands

Respiratory:

- [ ] Cough
- [ ] Congestion
- [ ] Wheezing
- [ ] Asthma
- [ ] Emphysema
- [ ] Pneumonia

Musculoskeletal:

- [ ] Joint Pain/Stiffness
- [ ] Joint Swelling
- [ ] Arthritis
- [ ] Osteoporosis
- [ ] Fibromyalgia
- [ ] Chronic Fatigue

Allergic / Immunologic:

- [ ] Food Allergies
- [ ] Airborne Allergies
- [ ] Systemic Lupus
- [ ] Cancer
- [ ] HIV/AIDS

Endocrine:

- [ ] Excessive Thirst/Urination
- [ ] Heat or Cold Intolerance
- [ ] Skin Becoming Drier
- [ ] Diabetes
- [ ] Thyroid Disorder

Genito-Urinary:

- [ ] Pain/Difficulty Urination
- [ ] Blood in Urine
- [ ] Incontinence
- [ ] Kidney Stones/Problems

Psychiatric:

- [ ] Anxiety/Depression
- [ ] Mood Swings
- [ ] Difficulty Sleeping
- [ ] Memory Loss

Hematologic / Lymphatic:

- [ ] Slow to heal after cuts
- [ ] Bleed or bruise easily
- [ ] Anemia
- [ ] Enlarged Glands

Integumentary:

- [ ] Rash/Sores
- [ ] Lesions
- [ ] Breast Pain or Lump
- [ ] Dermatitis/Eczema

Constitutional:

- [ ] Bad General Health
- [ ] Recent Weight Change
- [ ] Fever
- [ ] Fatigue
- [ ] Headaches

Eyes:

- [ ] Eye Disease/Injury
- [ ] Glasses or Contact Lens
- [ ] Blurred/Double Vision

Neurological:

- [ ] Seizures or Epilepsy
- [ ] Numbness/TIngling
- [ ] Tremors
- [ ] Stroke

LIST OF HOSPITALIZATIONS & SURGERIES

Falls

_____

Fractures

_____

Hospitalizations

_____

Surgeries

MEDICATIONS & ALLERGIES

Medications

Supplements

Allergies

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the clinic of any changes in my medical status.

Signature of Patient or Patient Representative

Date