Name_____ Today's Date_____ Date of Birth_____

Please place a check (√) if you **NOW have** any of following:

GENERAL
- ☐ Allergy
- ☐ Chills
- ☐ Convulsions
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Heat/cold intolerance
- ☐ Loss of sleep
- ☐ Mental or emotional disorders
- ☐ Nervousness
- ☐ Neuralgia
- ☐ Numbness
- ☐ Sweats
- ☐ Tremors
- ☐ Weight change

MUSCLE AND JOINT
- ☐ Bone fractures
- ☐ Foot trouble
- ☐ Joint dislocations
- ☐ Joint stiffness
- ☐ Low-back pain
- ☐ Neck pain or stiffness
- ☐ Pain in mid-back

Pain or numbness in:
- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Ribs

- ☐ Painful tailbone
- ☐ Poor posture
- ☐ Sciatica
- ☐ Spinal curvature
- ☐ Sprains/strains
- ☐ Swollen joints

NEUROLOGICAL
- ☐ Seizures
- ☐ Syncope
- ☐ Sensory disturbances
- ☐ Stroke
- ☐ Head trauma

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Belching or gas
- ☐ Black or bloody stool
- ☐ Colitis
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Difficulty in swallowing
- ☐ Distention of abdomen
- ☐ Excessive hunger
- ☐ Gall bladder trouble
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

EYES, EARS, NOSE & THROAT
- ☐ Asthma
- ☐ Colds
- ☐ Crossed eyes
- ☐ Dental decay
- ☐ Difficulty hearing
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear noises
- ☐ Enlarged glands
- ☐ Enlarged thyroid
- ☐ Eye pain
- ☐ Failing vision
- ☐ Far sightedness
- ☐ Gum trouble
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Near sightedness
- ☐ Nose bleeds
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tinnitus
- ☐ Tonsillitis

FOR MEN ONLY
- ☐ Testicular mass
- ☐ Testicular pain

CARDIOVASCULAR
- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Orthopnea
- ☐ Pain over heart
- ☐ Paroxysmal nocturnal dyspnea
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

SKIN
- ☐ Boils
- ☐ Bruise easily
- ☐ Change in mole
- ☐ Dryness
- ☐ Hives or allergy
- ☐ Itching
- ☐ Skin eruptions (rash)
- ☐ Varicose veins

RESPIRATORY
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Cough up blood
- ☐ Difficult breathing
- ☐ Spitting up phlegm
- ☐ Wheezing

GENITO-URINARY
- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Hesitancy
- ☐ Incontinence
- ☐ Intermittency
- ☐ Kidney infection or stones
- ☐ Painful urination
- ☐ Prostate trouble
- ☐ Urethral discharge

FOR WOMEN ONLY
- ☐ Breast lump
- ☐ Breast pain
- ☐ Cramps or backache
- ☐ Excessive menstrual flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ Painful menstruation
- ☐ Vaginal discharge
- ☐ Are you pregnant?

Please place a check (√) if you **now have** or have **ever previously had** any of following conditions:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Venereal disease
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Scarlet fever
- ☐ Shingles
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Other_____

Please **briefly** explain any hospitalizations or surgeries_____

_____

Please Continue On The Reverse Side

What prescription or over-the-counter medications are you currently taking? _____

_____

Who is your primary care doctor and when was your last visit? _____

_____

Please place a check (√) in the box that best describes you:

SOCIAL HISTORY	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Recreational drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Please place a check (√) in the box that best describes the effects of your current condition on daily activities:

ACTIVITY	No effect	Pain		No effect	Pain
Bending	☐	☐	Household chores	☐	☐
Carrying groceries	☐	☐	Lifting	☐	☐
Sit to stand	☐	☐	Pet care	☐	☐
Climbing stairs	☐	☐	Self care	☐	☐
Driving	☐	☐	Walking	☐	☐
Using the computer	☐	☐			

Is there any other information about your health history that we should be aware of? Please explain_____

_____

Have you sought treatment from another doctor? _____ If yes, please provide a **brief** explanation_____

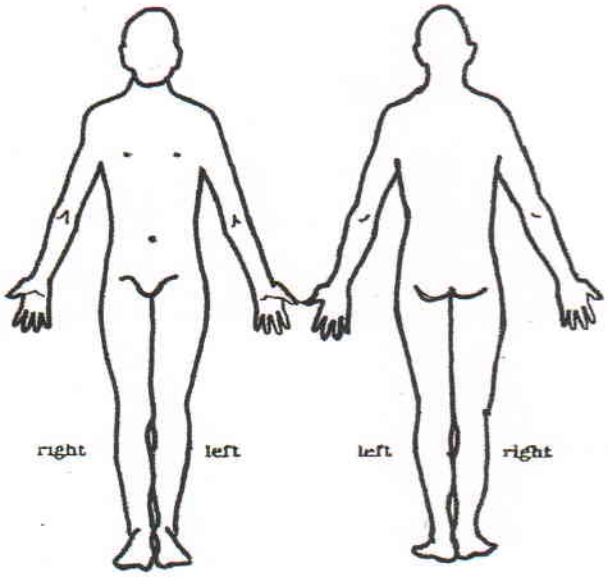
_____

Mark on the pain scale from 0 to 10 the pain you feel: ☐—☐—☐—☐—☐—☐—☐—☐—☐—☐—☐

No pain Excruciating

Draw the appropriate symbol(s) on the body of where you feel the MOST pain:

Numbness	pins & needles	burning	aching	stabbing
___	000	xxx	***	///



_____

Return When Complete