

**PATIENT NAME:** \_\_\_\_\_ **DATE** \_\_\_\_\_

**What problem or difficulty brought you to this office?** \_\_\_\_\_  
\_\_\_\_\_

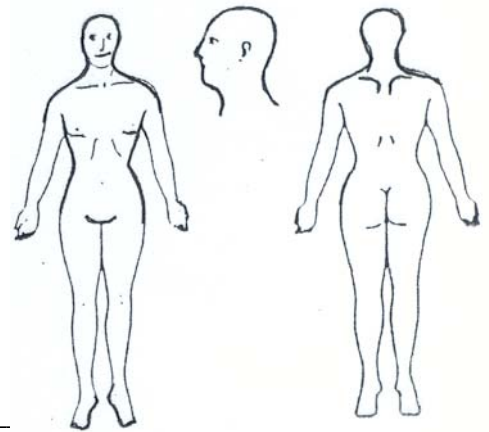
**When did this problem start? Give Date:** \_\_\_\_\_

**What caused this problem (an accident, injury?, details, please)** \_\_\_\_\_  
\_\_\_\_\_

**Please mark on the figure and circle your problems below.**

(Circle all that apply)

- Sharp pain    Constant pain    Dull Ache    Pain with Movement
- Soreness    Tenderness    Weakness    Burning    Throbbing
- Tightness    Stabbing    Numbness/Tingling    Spasm
- Radiates (spreads to somewhere else)    Deep Ache
- Pins and Needles    Other \_\_\_\_\_



**Have you had this problem before?** \_\_\_\_\_

**What treatment did you have for this problem previously?** \_\_\_\_\_

**Has it gotten better or worse since it started?    Same:** \_\_\_\_\_ **Better:** \_\_\_\_\_ **Worse:** \_\_\_\_\_

**How frequently do you have it? (Circle)** All of the time    A few hours at a time    Daily    Occasionally

**What makes it feel better?** Rest \_\_\_\_\_ Movement \_\_\_\_\_ Heat \_\_\_\_\_ Cold \_\_\_\_\_ Special Position \_\_\_\_\_  
Medication \_\_\_\_\_ Other: \_\_\_\_\_

**What makes it feel worse?** Standing \_\_\_\_\_ Sitting \_\_\_\_\_ Laying Down \_\_\_\_\_ Walking \_\_\_\_\_ Lifting \_\_\_\_\_  
Twisting \_\_\_\_\_ Bending \_\_\_\_\_ Changing Positions \_\_\_\_\_ Looking Up/down \_\_\_\_\_ Turning Head \_\_\_\_\_  
Climbing Stairs \_\_\_\_\_ Cough/Sneeze \_\_\_\_\_ Other: \_\_\_\_\_

**Do you have any illness that may be causing these symptoms?** \_\_\_\_\_

**Do you have/had any major illnesses, injuries or diseases, now or in the past?** \_\_\_\_\_  
\_\_\_\_\_

**RATE YOUR PAIN (Circle)**    (No symptoms)    1    2    3    4    5    6    7    8    9    10    (Extreme Pain)

**AGE:** \_\_\_\_\_ **HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_

Page 2. **Patient Name:** \_\_\_\_\_

**Do you exercise?** Heavy \_\_\_\_\_ Moderate \_\_\_\_\_ Light \_\_\_\_\_ What exercise do you do? \_\_\_\_\_

**Do you have a lot of stress?** Heavy \_\_\_\_\_ Moderate \_\_\_\_\_ Light \_\_\_\_\_

**How is your diet?** Good \_\_\_\_\_ Regular \_\_\_\_\_ Sporadic \_\_\_\_\_ Poor \_\_\_\_\_ Not Hungry \_\_\_\_\_

**Bowel Habits:** Normal \_\_\_\_\_ Irregular \_\_\_\_\_ **Bladder Habits:** Normal \_\_\_\_\_ Abnormal: \_\_\_\_\_

**Do you take vitamins or supplements?** \_\_\_\_\_

**Are you allergic to anything? What?** \_\_\_\_\_

**List all prescription drugs and supplements that you take:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you take, or have you ever taken: Prednisone, cortisone, or other steroid including injection or inhaler?**  
Yes \_\_\_\_\_ No \_\_\_\_\_

**Have you ever made a Workers Compensation Claim for injury at work?** Yes \_\_\_\_\_ No \_\_\_\_\_ When \_\_\_\_\_

**Have you ever had an Auto Accident?** Yes \_\_\_\_\_ No \_\_\_\_\_ When: \_\_\_\_\_  
**Fractures? Of What?** \_\_\_\_\_ **Slip and Fall Accident?** \_\_\_\_\_

**List all Previous Surgery:** \_\_\_\_\_  
\_\_\_\_\_

**List all Previous Hospitalizations** \_\_\_\_\_  
\_\_\_\_\_

**What X-rays have you had in the last five years?** \_\_\_\_\_

**Have you had an EKG in the last five years?** Yes \_\_\_\_\_ No \_\_\_\_\_ **MRI:** Yes \_\_\_ No \_\_\_ **Of What?** \_\_\_\_\_  
**CT Scan** Yes \_\_\_ No \_\_\_ **Of What?** \_\_\_\_\_

**Does any member of your immediate family (blood relative) have any serious disease or illness?**  
**Relationship:** \_\_\_\_\_ **Illness or Disease:** \_\_\_\_\_  
\_\_\_\_\_

**Have you ever had any of the following diseases or illnesses? (Circle if YES)**

Cancer    Tuberculosis    Diabetes    Heart Trouble    High Blood Pressure    Stroke    Epilepsy  
Mental Illness    Hepatitis A B C D    Transient Ischemic Attack (TIA)    Syncope  
Measles    German Measles    Mumps    Chicken Pox    Pneumonia    Pleurisy    Arthritis  
Rheumatism    Polio    Meningitis    Nephritis    Kidney Stones    Venereal Disease  
Gallbladder Disease    Anemia    Jaundice    Migraine Headaches    Rheumatic Fever    Osteoporosis  
Chronic Obstructive Lung Disease    Any Bone or Joint Disease  
Any Other Serious Illness or Disease not listed \_\_\_\_\_

**Are you HIV Positive (AIDS) or do you have AID'S Related Complex?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Do You Have Hepatitis C?** Yes \_\_\_\_\_ No \_\_\_\_\_

**DO YOU HAVE NOW OR HAVE YOU HAD IN THE LAST YEAR: (Circle if YES)**

Frequent headaches	Severe intensity headaches	Dizziness with change of position
Loss of Consciousness	Blurred Vision	Double vision
Spots before eyes	Infected eyes	Pain Between Eyes
Vision Changes	Do You Wear Glasses? Last Examined _____	
Ear Aches	Discharge from ears	ringing in ears
Decrease in hearing	Recurrent nose bleeds	Recurrent head colds
Sinus problems	Hay fever	Strange or persistent odors
Strange or loss of taste	Persistent hoarseness	Difficulty swallowing
Enlarged glands	Recurrent sore throat	Recurrent sores in mouth
Soreness or bleeding gums	Chest pain	Angina
Coughed up blood	Pain in arm(s)	Night sweats
Chronic cough	Cough when lying down	Night shortness of breath
How many pillows do you use? _____		
Shortness of breath with _____ walking several blocks, _____ one flight of stairs, _____ on laying down		
Purple fingers or lips	Palpitations	High Blood Pressure
Swelling of hands	Swelling of feet	Swelling of ankles
Leg cramps with walking	Leg Cramps at night	Enlarged veins in legs
Recurrent stomach pain	Belching/Heartburn? Relieved by _____ Eating?,	
Poor Appetite	Nausea	Vomiting
Avoid which foods? _____		

Abdominal cramping	Abnormal color bowel movement	Pain with Bowel Movement
Loss of Urine w/ coughing or sneezing		
Difficulty starting urine stream	Urinate frequently	Urinate less frequently
Blood in Urine	How frequently do you urinate at night? _____	
Joint pain	Swelling of joints	Redness/heat in joint
Tingling or weakness in hands or feet		
Less or change of sensation in hands or feet		
Trembling of hands or feet		
Muscle spasms	Muscle pain	Muscle cramps
Hot flashes	Tiredness with no reason	Brittleness of nails
Dryness of skin	Easy bruising	Inability to stand heat
Change of hair texture	Change of skin texture	

**Men:**  
 Discharge from penis \_\_\_\_\_ Difficulty achieving or maintaining erection \_\_\_\_\_ Pain on urination \_\_\_\_\_

**Have you been told you have OSTEOPOROSIS OR OSTEOPENIA? By Whom? \_\_\_\_\_**

**WOMEN:**

ARE YOU PREGNANT? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Menstrual History: Age at Onset \_\_\_\_\_ Cycle: \_\_\_\_\_ (days)  
 Flow: Heavy \_\_\_\_\_ Moderate \_\_\_\_\_ Light \_\_\_\_\_  
 Pain: Yes \_\_\_\_\_ No \_\_\_\_\_ Cramps: Yes \_\_\_\_\_ No \_\_\_\_\_ Date of Last Period \_\_\_\_\_  
 Date of Last Pelvic Exam \_\_\_\_\_ Pap Test? \_\_\_\_\_  
 Vaginal discharge? Yes \_\_\_\_\_ No \_\_\_\_\_ Itching? Yes \_\_\_\_\_ No \_\_\_\_\_ Birth Control Pills? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Pregnancies; Number \_\_\_\_\_ Still Births \_\_\_\_\_ Premature Babies \_\_\_\_\_ C Sections \_\_\_\_\_

**EVERYONE**

**Do you drink alcohol?** Heavy Moderate Light None Quantity \_\_\_\_\_  
**Do you use caffeine?** Heavy Moderate Light None Quantity \_\_\_\_\_  
**Do you use Tobacco?** Heavy Moderate Light None Quantity \_\_\_\_\_  
**Do you abuse any Drugs or other Substances?** Yes No Which Ones \_\_\_\_\_