



Patient Name: _____ Date of Birth: _____
 Date: _____ Employer's Name: _____
 Address: _____ Phone No.: _____

<p>What is your main complaint?</p> <p>_____</p> <p>_____</p> <p>Describe in detail.</p> <p>_____</p> <p>_____</p> <p>When is it most troublesome?</p> <p>_____</p> <p>Does it "come and go"?</p> <p>_____</p> <p>If so, at predictable times?</p> <p>_____</p> <p>When did it begin?</p> <p>Date _____</p> <p>What caused it? _____</p> <p>Was it work related? _____</p> <p>Was it related to an auto accident?</p> <p>_____</p> <p>Was it related to an injury?</p> <p>_____</p> <p>Have you seen any other doctor, since it began?</p> <p>_____</p> <p>If so, other doctors' names and Addresses</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>What relieves this problem?</p> <p>_____</p> <p>When does it bother you most?</p> <p>_____</p> <p>What do you expect our care to accomplish?</p> <p>_____</p> <p>Indicate any secondary complaint.</p> <p>_____</p> <p>Describe in detail.</p> <p>_____</p> <p>When is it most troublesome?</p> <p>_____</p> <p>Do you have any other complaints or conditions?</p> <p>_____</p> <p>Describe in detail.</p> <p>_____</p> <p>_____</p> <p>Printed Name</p> <p>_____</p> <p>Signature</p> <p>_____</p>
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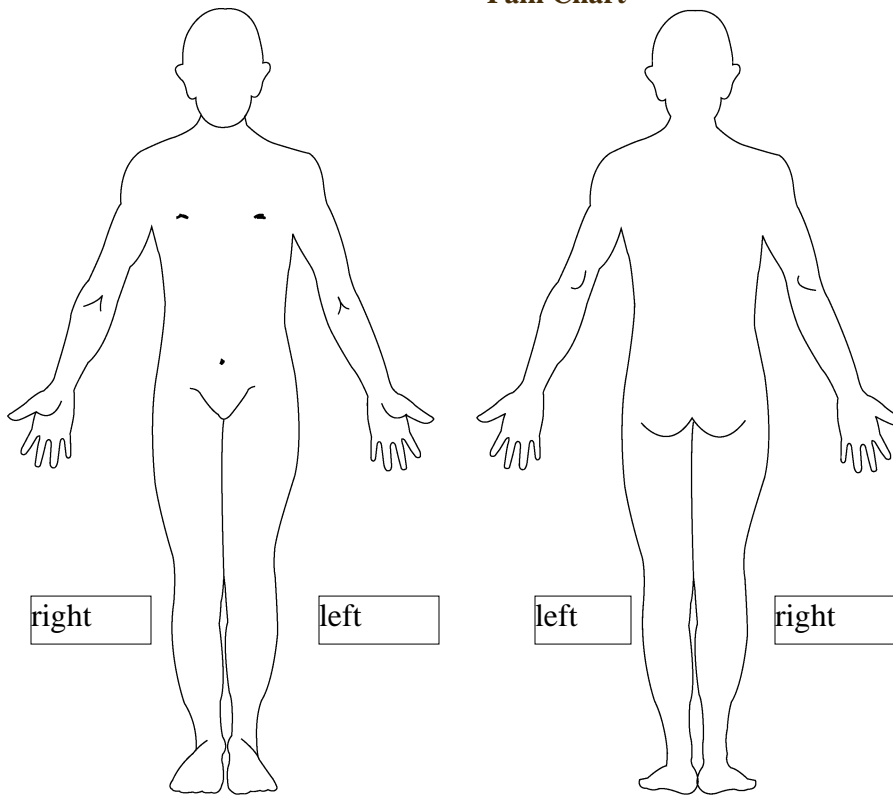
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
 Use the appropriate symbols.
 Mark areas of radiation.
 Include all affected areas.

Numbness	Pins & Needles Burning	Aching	Stabbing	
-----	00000	XXXXX	*****	/////
-----	00000	XXXXX	*****	/////
-----	00000	XXXXX	*****	/////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition.
 10 being the worst pain you have felt with this condition.

Pain Chart



Neck-Shoulder-Arm-Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
no pain **severe pain**

Mid Back Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
no pain **severe pain**

Low Back and Leg Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
no pain **severe pain**

Date: _____

 Signature



PATIENT NAME: _____
DATE OF BIRTH: _____
DATE: _____

CASE NO. _____

- Do you have vertigo (dizziness)? Yes _____ No _____
- Do you pass out easily (faint or loss of consciousness)? Yes _____ No _____
- Do you have double vision or have you lost sight in one eye? Yes _____ No _____
- Do you have any slurred speech or difficulty with speech? Yes _____ No _____
- Do you have indigestion or difficulty swallowing? Yes _____ No _____
- Do you have any difficulty walking, with coordination or falling to one side? Yes _____ No _____
- Do you have nausea or vomiting? Yes _____ No _____
- Do you have numbness on one side of your face or body? Yes _____ No _____
- Do you have any visual disturbances or rapid eye movement? Yes _____ No _____
- Do you have or have you ever had difficulty in arranging words properly? Yes _____ No _____
- Do you have a headache or head pain that is unlike any you have had before? Yes _____ No _____
- Do you have headaches for hours or days? Yes _____ No _____
- Do you have a history of stroke in your family? Yes _____ No _____
- Do you have chest pain? Yes _____ No _____
- Do you have any change in bowel or bladder habits? Yes _____ No _____
- Do you have a sore that does not heal? Yes _____ No _____
- Do you have any unusual bleeding or discharge? Yes _____ No _____
- Do you have any thickening in your breasts or elsewhere? Yes _____ No _____
- Do you have a change in any wart or mole? Yes _____ No _____
- Do you have a nagging cough or hoarseness? Yes _____ No _____
- Do you have night sweats? Yes _____ No _____
- Do you have pain in neck, jaw or face? Yes _____ No _____
- Do you have a drooping eyelid or change in your pupils? Yes _____ No _____
- Do you have any ringing in your ears? Yes _____ No _____
- Do you take birth control pills? Yes _____ No _____

What prescription medication are you taking if any?

- High blood pressure medication
- Blood thinners
- Herb, vitamins, or over the counter products
- Other _____
-

Have you ever had cancer? Yes ___ No ___
 Does your pain ever wake you from a sound sleep? Yes ___ No ___
 Are you losing weight now without trying? Yes ___ No ___
 Are you coughing up blood or noticing it in your stools or urine? Yes ___ No ___
 Have you had any loss of bladder or bowel control? Yes ___ No ___
 Have you lost consciousness or had double vision recently? Yes ___ No ___
 Are you seeing any other doctor now for any reason? Yes ___ No ___

Note: _____
 Are you taking any medication or over-the-counter drugs? Yes ___ No ___
 Please indicate type (aspirin, etc.) _____
 Are you taking herbs, nutraceuticals, botanicals, or vitamins?
 Please list _____
 What was the date of onset of your last menses? _____

Social History

SMOKER _____ Yes or _____ No, If Yes, how many packs _____
 ALCOHOL _____ Yes or _____ No, If Yes, how much _____

Family History

Did you mother or father have any of the following:
 Put an **M** for mother, **F** for father, and **B** for both.

- | | |
|---|---|
| <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Seizure-Convulsions
<input type="checkbox"/> HIV Positive
<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcer or Stomach Problems
<input type="checkbox"/> Stroke (Please indicate age when stroke occurred,
Mother _____ Father _____)
<input type="checkbox"/> Arthritis-Rheumatism
<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Circulation Problems
<input type="checkbox"/> Cancer |
|---|---|

Comments: _____

Date: _____ Signature _____