Today's Date: _____

Name: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office:

Primary or Chief Complaint: _____

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen? _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaint by ***circling the number*****:**
Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Secondary: _____

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen? _____

Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

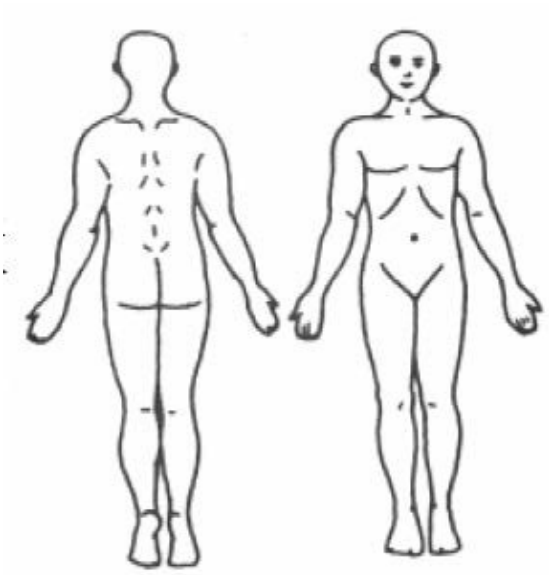
Third: _____

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen? _____

Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

_____

What makes your symptoms feel worse? _____

_____

Continue on next page

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when:_____by whom? _____

How long were you under care:_____ What were the results? _____

Name of Previous Doctor: _____ ☐ **N/A**

List Prescription & Non-Prescription drugs/supplements you take:

_____

_____

_____

PLEASE identify ALL PAST and any **CURRENT** conditions:

	HOW LONG AGO	TYPE OF CARE RECEIVED
INJURIES →		
SURGERIES →		
CHILDHOOD DISEASES →		
ADULT DISEASES →		

SOCIAL HISTORY

1. Tobacco: ☐cigars ☐pipe ☐cigarettes ☐chew How often? ☐ Daily ☐Weekends ☐Occasionally ☐Never

2. Alcoholic Beverage: consumption occurs ☐Daily ☐ Weekends ☐Occasionally ☐Never

3. Recreational Drug use: ☐Daily ☐Weekends ☐Occasionally ☐Never

4. Caffeine: ☐ Daily ☐Weekends ☐Occasionally ☐Never

Patient Name: _____ Today's Date: ___/___/___

Continue on next page

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life. Please only select one effect per activity:

ACTIVITIES:	EFFECT: Please select only one per activity			
Carry Objects	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Objects	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressesd	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Vacuuming	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Garbage	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other:_____	☐ No Effect	☐Painful (can do)	☐Painful (limits)	☐ Unable to Perform

Patient Name: _____ Today's Date: ___/___/___

Continue on next page

Please review the following list of medical problems and mark all that apply to you. Please review carefully. Medical conditions that do not seem related to your current situation could result in a serious complication if you do not let us know.

Constitutional
- ☐ Recent change in weight
- ☐ Fatigue
- ☐ Weakness of arm/leg
- ☐ Numbness of arm/leg
- ☐ Headaches/Migraines
- ☐ Loss of consciousness
- ☐ Sinus problems
- ☐ Hay fever allergies
- ☐ Difficulty hearing
- ☐ Difficulty swallowing

Cardiovascular/ Respiratory
- ☐ Heart murmur/irregular heart beat
- ☐ Heart pacemaker/defibrillator
- ☐ Chest pain or angina with exertion
- ☐ Heart disease
- ☐ Swelling in feet or ankles
- ☐ Shortness of breath
- ☐ Bleeding disorders
- ☐ Blood clots
- ☐ High blood pressure
- ☐ Asthma

Gastrointestinal
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Difficulty with bowel/bladder function

Musculoskeletal
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Herniated disc
- ☐ Pinched nerve

Integumentary/Dermatologic
- ☐ Skin rash or sores

Neurologic
- ☐ Seizures or convulsions
- ☐ Stroke
- ☐ Brain aneurysm or hemorrhage
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Muscular dystrophy

Psychiatric
- ☐ Depression
- ☐ Anxiety or panic attacks
- ☐ Psychiatric care
- ☐ Suicide attempt

Endocrine
- ☐ Diabetes Type ☐ I or ☐ II
- ☐ Thyroid conditions
- ☐ Goiter
- ☐ Steroid use

Lymphatic
- ☐ Swollen glands or masses
- ☐ Breast lump
- ☐ Lymphedema

Illness / Disease
- ☐ Chicken pox
- ☐ Gout

Other
- ☐ Alcoholism
- ☐ Appendicitis
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Tumor or growth
- ☐ Venereal disease
- ☐ Other

For women only

Are you pregnant Yes No
Are your menstrual cycles regular Yes No
Date of last menstruation _____

For men only
- ☐ Testicular pain
- ☐ Prostate condition

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes
If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ son(s) ☐ daughter(s)
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

Patient Name_____

Patient signature: _____ **Today's Date:** ___/___/___

_____ ___/___/___
Providers's Signature **Date Form Reviewed**