Patient Name:_____ Patient DOB:_____

Date Of Service: _____

Other Symptoms	YES	NO	Explanation
Systemic: Fever, chills, fatigue, night sweats, weight loss			
Head: headache, recent head trauma			
Neck: stiffness, swollen glands			
Eyes: eye injury, vision loss, photophobia, ocular pain, double vision blurry vision			
Otolaryngeal: ear pain or discharge, ringing, impaired hearing, vertigo, chonic sinus issues, nosebleeds, loss of smell, post nasel drip, throat soreness, hoarseness, change in voice, gum bleeding, difficulty swallowing			
Breast: Lumps, discharge			
Cardiovascular: chest pain, irregular heartbeat, palpatations, leg swelling, syncope, shortness of breath			
Pulmonary: Cough, dyspnea, hemoptysis wheezing			
Gastrointestinal: abdominal pain, change in appetite, constipation, diarrhea, heartburn, nausea, vomiting, rectal bleed			
Genitourinary: incontinence, frequent urination, burning or painful urination blood in urine			
Endocrine: Thyroid disease, increased thirst or uncontrolled hunger			
Hematologic: anemia, easy bruising or bleeding			
Musculoskeletal: back or neck pain, weakness in extremeties, body aches, calf tenderness, joint swelling and pain			
Neurological: loss of consciousness, seizures, focal weakness/ paralysis, gait disturbance, headache, memory impairment, numbness/ tingling, speech disturbances, tremors/shaking			
Psychological: Anxiety, depression, insomnia, psyciatric symptoms			
Skin: Rashes, hives, changes in color or texture of skin			

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Patient Name: _____

Living Situation "Lives with": _____

Age: _____

Current Occupation / Prior Occupation (If retired or disabled): _____

_____

Name of Primary Care Physician: _____

Address: _____

Phone Number: _____ Fax Number: _____

2nd treating physician: _____

Address: _____

Phone Number: _____ Fax Number: _____

3rd treating physician: _____

Address: _____

Phone Number: _____ Fax Number: _____

MEDICAL AND HEALTH CARE INFORMATION

PATIENT NAME: _____

DRUG ALLERGIES: 1)_____ 2)_____

3)_____ 4)_____

CURRENT STATUS: Right Handed_____ Left Handed_____ Weight_____ Height_____

Coffee/Tea (cups/day) _____ Alcohol (quantity/day) _____

Tobacco (packs/day) _____ Other Tobacco (quantity/day) _____

Recreational Drug Use (Marijuana, cocaine, etc.) _____

CURRENT MEDICATIONS:

PRESCRIPTION NAME	DOSE	FREQUENCY

NON-PRESCRIPTION NAME	DOSE	FREQUENCY

ACCIDENTS OR INJURIES:

Description:_____

_____

Related to: Work Car Accident Motorcycle Other_____

Date of Accident_____ Disabled from_____ thru_____

CURRENT SYMPTOMS OR COMPLAINTS: _____

_____

_____

_____

_____

MEDICAL AND HEALTH CARE INFORMATION

PATIENT NAME: _____

PAST MEDICAL HISTORY: Please check those that apply.

Aids_____	Drug Addiction____	Kidney Disease____
Alcoholism_____	Emotional Problems____	Pneumonia_____
Anemia_____	Epilepsy_____	Rheumatic Fever_____
Asthma_____	Gall Bladder____	Stomach/Ulcers_____
Back/Neck Injuries_____	Headaches/Migraine_____	Stroke_____
Bleeding Tendency_____	Heart Disease_____	Thyroid Disease_____
Cancer_____	High Blood Pressure_____	Tuberculosis_____
Diabetes_____	HIV Infection_____	Other(pls. explain)_____

FAMILY HISTORY: Please check those that apply.

Tuberculosis_____	High Blood Pressure___	Anemia____
Rheumatic Fever_____	Mental Disease_____	Stroke____
Stomach Problems_____	Diabetes_____	Arthritis_____
Lung Disease_____	Thyroid Disease_____	Glaucoma_____
Kidney Disease_____	Heart Disease_____	Cancer_____
Bleeding Tendency_____	Other: _____	

	ILLNESSES	If Deceased-At What Age
MOTHER		
FATHER		
SIBLINGS		
SPOUSE		
CHILDREN		

PREVIOUS SURGERIES/HOSPITALIZATIONS/TESTS:

DATE	HOSPITAL/FACILITY	REASON

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Body Pain Diagram

In the diagrams provided below, please mark the areas on your body which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include *all* area. Use the symbols provided below.

Please use the symbols In this key to show the sensation/pain you are feeling.

Numbness

Burning
Xxxxxxxxx

Dull/ Aching
+++++++++

Pins & Needles
Oooooooooo

Stabbing / Sharp
//////////

Stiff / Tight
22222222