Patient Name: _____ Date: _____

Surgical History

Surgery	Year

Family History – immediate family only: mother, father, siblings, children

	YES	NO	COMMENTS
Cancer	☐	☐	Type:
Diabetes	☐	☐	
Heart Disease	☐	☐	
Liver Disease	☐	☐	
Kidney Disease	☐	☐	
Stroke	☐	☐	

Medications: Please list ALL medication you take, both prescription and non-prescription OR provide us with a medication list.

Name of Medication	Dose	Frequency

Allergies: Please list drug and non-drug allergies

Drug or Allergen	Reaction

Patient Name: _____ Date: _____

Health History

Please complete the following regarding your health history. Mark all boxes that apply.

	YES	NO	COMMENTS
Asthma	☐	☐	
COPD	☐	☐	
Obstructive Sleep Apnea	☐	☐	
High Cholesterol	☐	☐	
High Blood Pressure	☐	☐	
Heart Attack	☐	☐	
Heart Disease	☐	☐	
Stroke	☐	☐	
Liver Disease	☐	☐	☐ Hepatitis ☐ Cirrhosis ☐
Kidney Disease	☐	☐	☐ Kidney Failure ☐ Stones ☐
Gastrointestinal Disease	☐	☐	☐ Ulcers ☐ Reflux ☐ Colitis ☐
Bleeding Disorders	☐	☐	
Diabetes	☐	☐	
Thyroid Disorders	☐	☐	
Rheumatoid Arthritis	☐	☐	
Osteoporosis	☐	☐	
Cancer	☐	☐	Type:
Fibromyalgia	☐	☐	
HIV/AIDS	☐	☐	
Psychiatric Disease	☐	☐	☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Schizophrenia ☐
Neurological Disease	☐	☐	☐ Parkinson ☐ Cerebral Palsy ☐ Seizures ☐ Neuropathy ☐ Multiple Sclerosis ☐ Migraines
Drug Abuse	☐	☐	
Alcohol Abuse	☐	☐	
Pregnant currently	☐	☐	
Other Conditions	☐	☐	Please list:

Social History

Substance	Currently use? (Please circle)	Previously used? (Please circle)	Type/Amount/Frequency	How Long? (Years)	If quit, when? (Year)
Caffeine	Yes No	Yes No			
Tobacco	Yes No	Yes No			
Alcohol	Yes No	Yes No			
Illegal drugs	Yes No	Yes No			

Patient Name: _____ Date: _____

Review of Systems

Please check all symptoms you have had regularly in the last **MONTH**:

GENERAL	YES	NO
Unexplained weight loss	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Night sweats	☐	☐

EYES	YES	NO
Eye disease or eye injury	☐	☐
Blurry vision	☐	☐
Double vision	☐	☐

EARS, NOSE, and THROAT	YES	NO
Hearing loss	☐	☐
Ringing in ears	☐	☐
Nosebleeds	☐	☐

CARDIOVASCULAR	YES	NO
Chest pain	☐	☐
Fast/irregular heartbeat	☐	☐

RESPIRATORY	YES	NO
Frequent coughing	☐	☐
Spitting up blood	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐

NEUROLOGICAL	YES	NO
Frequent or recurrent headaches	☐	☐
Light headed or dizzy	☐	☐
Convulsions or seizure	☐	☐

PSYCHIATRIC	YES	NO
Memory loss or confusion	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Suicidal thoughts	☐	☐

GASTROINTESTINAL	YES	NO
Loss in appetite	☐	☐
Change in bowel movements	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Frequent diarrhea	☐	☐
Constipation	☐	☐
Stomach pain	☐	☐

GENITOURINARY	YES	NO
Frequent urination	☐	☐
Burning or painful urination	☐	☐
Incontinence	☐	☐
Date of last menstrual period	___/___/____	

MUSCULOSKELETAL	YES	NO
Muscle weakness	☐	☐
Joint pain	☐	☐
Muscle pain or cramps	☐	☐
Back pain	☐	☐
Neck pain	☐	☐

SKIN	YES	NO
Rash	☐	☐
Itching	☐	☐
Skin infection	☐	☐

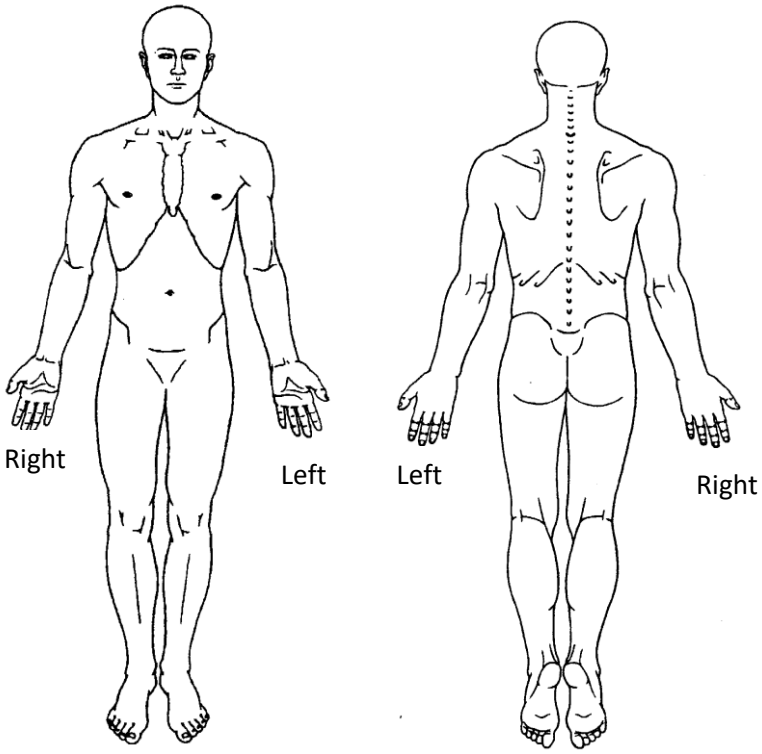
ENDOCRINE	YES	NO
Excessive thirst	☐	☐
Heat intolerance	☐	☐
Cold intolerance	☐	☐

HEMATOLOGIC	YES	NO
Easily bruise or bleed	☐	☐
Chemotherapy/radiation	☐	☐

Patient Name: _____ Date: _____

CURRENT PROBLEM

Please shade in where your primary pain is located using the diagrams below. Please keep in mind that all areas of pain may not be able to be addressed in one visit.



When did the pain begin? _____

Did it begin gradually or suddenly? _____If suddenly, is it the result of an injury? ____Yes ____No

If result of an injury, describe the injury:_____

_____

If not a result of injury, what do you think caused your pain? _____

_____

Since your pain started is it: Worse Unchanged Intermittent Better (please circle one)

Please describe your pain in as much detail as possible, including symptoms such as numbness, weakness, or pins and needles sensation.

_____

_____

What kinds of treatment have you tried for this pain? (Ex: chiropractic, physical therapy, medical equipment, medications, injections)

_____

_____