*PatientName*____Date__________
Last First Middle

Address________________________________City____________________Zip________

E Mail________________________________DOB__________ SSN________________

Home phone________________________Cell phone______________________________

Race____________Ethnicity____________Sex orientation__________Birth gender__________

Primary language________________Preferred Language________________Interpreter needed? Yes No

Marital status ______Spouse name____________________ Spouse phone______________

Nearest Relative____________________ Nearest relative phone____________________

Employer________________________________Work phone____________________

Name of Primary Physician__________________________Tel #____________________

Name of Referring Physician__________________________ Tel#____________________

Please List your **Current Symptoms** in order of Severity:

#	Description: What and where	When did It start?	Frequency	Pain level 1-10
1				
2				
3				
4				
5				
6				

Are you here for treatment of an injury? Yes No **If yes, what kind?** **( )** Auto ( ) Work ( ) Other

Explain briefly, listing date(s) of injury____

____

Do you have pain? Yes No. If yes, where? ______________________________________

____

Describe: ***Mild Severe Moderate Dull Sharp Hot Cold Moving Fixed Continuous Intermittent Like a needle Pulling Heavy***

How has your life been impacted by these complaints? Which of your activities have been affected?

Work and Career____

Family and Personal Life____

Mental State and Attitude____

____

Last known Blood Pressure____________Date____ ____Height________Weight__________

Do you have a medical condition(s) that has been diagnosed? Yes No If yes, please list:

1.____ Date of onset:____________________

2.____ Date of onset:____________________

3.____ Date of onset:____________________

4.____ Date of onset:____________________

5.____ Date of onset:____________________

Please list your Major Surgeries, Illnesses, Accidents and Hospitalizations, Indicate the year :

Surgeries: ____

Illnesses: ____

Accidents: ____

Hospitalizations: ____

Electronic implanted devices:
Pace maker, Spinal cord stimulator etc.____

Have you ever had Hepatitis? Yes No Do you have High Blood Pressure? Yes No

Are you HIV positive? Yes No Do you have Lupus? Yes No

Do you have COPD? Yes No Do you have Diabetes? Yes No

Do you have any dental problems? Yes No Are you taking blood thinner meds? Yes No

If yes, please explain____

____

Please list all of the Medications, Herbs and Dietary Supplements that you are currently using:

Medications prescribed / over the counter:____________________________________

____

Medication sensitivites:____
Herbs, Vitamins, and other
supplements____

____

Do you use Tobacco Products? Yes No Other Drugs Recreationally? Yes No

Take more than 8 drinks per week? Yes No **If yes, please document:**

Tobacco per day________________________Alcoholic beverages per day________________________

Recreational drugs____

Do you exercise? Yes No If yes, describe briefly: ____________________________________

____

Do you have any allergies? Yes No If yes, please list:

To medicines:____

To foods:____

Environmental Factors:____

Family History

Mother	*Father*
Current Health	***Current Health***
DOB *Place of Birth*	***DOB*** ***Place of Birth***
Major illnesses::	***Major Illnesses***

Significant Sibling History

Gender	***Age***	***Major illnesses***

Women's Issues:

Are you pregnant at this time? Yes No Not sure. Not applicable

Are you using birth control medications at this time? Yes No If yes, please list ______________________

____

Have you used them in the past? Yes No

If yes, when and for how long? ____

Are you taking medications for menopausal symptoms Yes No Not applicable.

If yes, please list:____

Please list the following:

1. Number of Pregnancies_________Number of live births__________Miscarriages___________Abortions______________

2. Age at first monthly period _______________________ 3. Date of last monthly period______________________________

4. If applicable: PMS Section. Describe your monthly period: Heavy, light, painful, dark colored clots, intermittent,

Other: ____

Significant PMS Symptoms Women only:

Pain: Yes No Low back Abdomen Headache Legs **Bloating:** Yes No **Edema:** Yes N
Depression: Yes No **Breast Tenderness:** Yes No **Hunger:** Yes No **Thirst:** Yes No
Anger: Yes No **Insomnia:** Yes No **Food Craving:**______________________

All Patients Complete the Review of Systems

Review of Systems: Please mark all conditions that apply to you

General: ( ) I tire easily ( ) I have a fever ( ) I have recent weight loss ( ) I have recent weight gain ( ) I have night sweats
Head Ears Eyes Nose Throat: ( ) I have glaucoma ( ) I have cataracts ( ) I wear glasses or contacts ( ) I have recent vision loss ( ) I see flashes of light ( ) I have floaters ( ) I have a mass in my neck ( ) I have neck pain ( ) I have neck stiffness ( ) I have swollen glands in my neck ( ) I have frequent nosebleeds ( ) I have seasonal allergies ( ) I have nasal drainage ( ) I have ringing in my ears ( ) I have hearing loss ( ) I have ear pain ( ) My teeth hurt ( ) I have bleeding gums ( ) I have dentures or plates ( ) I have loose teeth ( ) I have a hoarse voice
Hem/Endocrine: ( ) I have diabetes ( ) I have thyroid disease ( ) I have a bleeding disorder ( ) I have anemia ( ) I have HIV ( ) I bruise easily ( ) I have had blood clots
Cardiac: ( ) I have chest pains ( ) I have palpitations ( ) I have a heart murmur(s) ( ) I have an irregular heartbeat ( ) I faint frequently ( ) I have swelling in my legs ( ) I have heart failure ( ) I have high blood pressure
Respiratory: ( ) I have shortness of breath ( ) I have a cough ( ) I have a productive cough ( ) I have frequent wheezing ( ) I have asthma ( ) I have frequent colds and flu
GI/GU:( ) I have a mass in my belly ( ) I have belly pain ( ) I have bleeding ulcers ( ) I have heartburn regularly ( ) I have troubles swallowing ( ) I have frequent nausea and vomiting ( ) I have diarrhea ( ) I have constipation ( ) I have blood in my stool ( ) My stools are black ( ) I have changes in my bowel habits ( ) I have kidney disease ( ) I difficulty urinating ( ) I have blood in my urine ( ) I have painful urination ( ) I have incontinence of the bowel ( ) I have swollen glands in my neck and/or bladder ( ) I have a hernia ( ) I have hepatitis ( ) I have problems with ED or lack of arousal
Musculoskeletal ( ) My joints are stiff ( ) My joints hurt ( ) My joints are swollen ( ) My muscles are smaller ( ) Right handed ( ) My muscles hurt ( ) My muscles are weak ( ) I have gout ( ) I have rheumatoid arthritis ( ) Left handed
Skin: ( ) I have a rash ( ) I am being treated for a skin disorder ( ) I have HIV ( ) I bruise easily ( ) I itch ( ) I have moles ( ) I have sore that do not heal ( ) My nails have changed ( ) I am loosing hair
Neurological:( ) I have decreased memory ( ) I have dizziness ( ) I have frequent headaches ( ) I recently started to drop things ( ) I have seizures ( ) I have a tremor ( ) I have numbness and tingling ( ) I see double
Mental Health: ( ) My sleep habits have changed ( ) I am anxious ( ) I am depressed ( ) I have difficulty concentrating ( ) I have difficulty sleeping ( ) I have obsessive episodes ( ) I have frequent mood swings ( ) I currently see a counselor

Patient Signature: **Date:**