Date: _____

Last Name: _____ First Name: _____ Age: _____
DOB:_____

Please Describe the Location and Nature of Your Pain:

_____
_____

How Does It Limit You the Most? _____
Please Describe What Makes This Pain Worse and All the Ways This Pain Limits You i.e. work, walking, exercise, sleeping, standing, bending, lifting, concentrating...

_____
_____
_____
_____

MEDICAL HISTORY:
List Your Medical Diagnoses:
1) _____
2) _____
3) _____
4) _____
5) _____
Last Time You Had Blood Work Done and With What Doctor: _____

List All Traumas including Auto Collisions and Falls— Include Date Occurred:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List any Head & Neck Injuries if not mentioned above:

_____

When and What Were the Results of the Following:
X-ray: _____
MRI: _____
Nerve Conduction: _____
Musculoskeletal Ultrasound: _____

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Please List All Drug Allergies/Reactions:
Drugs: _____

Have You Ever Had a Cancer Diagnosis?: Y N
If Yes, Please Explain: _____
_____

SUBSTANCES:
Mark ALL that Apply: LEAVE BLANK if you've never had the symptom.
Check C if you CURRENTLY use the following substances. Check P if you have in the PAST.

SUBSTANCE	*C*	*P*
Antacids:	☐	☐
Steroids:	☐	☐
Analgesics:	☐	☐
Soda:	☐	☐
Ounces per day:	_____	
Energy drinks:	☐	☐
Tobacco:	☐	☐
Packs per day:	_____	
E-cigarette:	☐	☐
Marijuana/CBD:	☐	☐

SUBSTANCE	*C*	*P*
Recreational drugs:	☐	☐
Drug addiction:	☐	☐
Recreational drug treatment:	☐	☐
Type of drugs:		
_____		
Alcohol:	☐	☐
How much per day:	_____	
Alcohol addiction:	☐	☐
Alcohol treatment:	☐	☐

List all CURRENT Prescriptions, Supplements, & Herbs You Take: (Turn to page 5 for additional space)

Name of Supplement/Medication	Dosage	Frequency	Reason(s) for Taking	Does It Help? (Yes or No)

HEALTH HABITS
EXERCISE:
How often?:_____ What type(s)?:_____
How long?:_____

HOBBIES: _____

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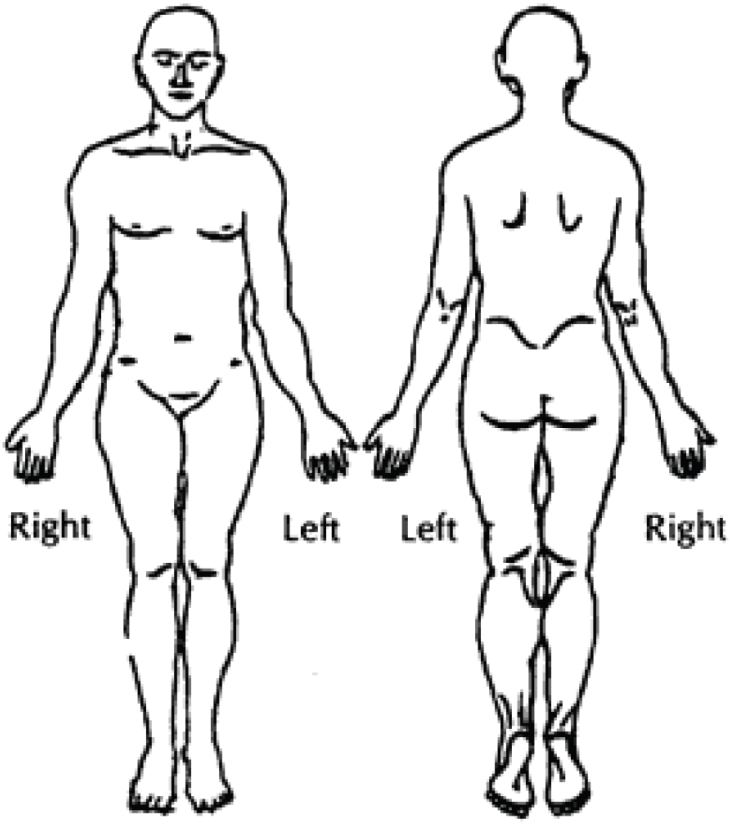
Pain Chart

Using the symbols below, mark on the body the areas where you feel that particular sensation.

Numbness	Pins & Needles	Burning	Aching	Sharp/Stabbing
//////	+++++	**00000**	**XXXXX**	*******



PLEASE CIRCLE YOUR LEVEL OF PAIN: (1 = Minimal Pain; 10= Worst Pain Imaginable)
PAIN CURRENTLY 1 2 3 4 5 6 7 8 9 10
PAIN AT ITS WORST 1 2 3 4 5 6 7 8 9 10
PAIN TYPICALLY 1 2 3 4 5 6 7 8 9 10

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FAMILY HISTORY:

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age (Living)	_____	_____	_____	_____	_____	_____
Age (Deceased)	_____	_____	_____	_____	_____	_____
Reason for Death	_____	_____	_____	_____	_____	_____
Cancer (Type)	_____	_____	_____	_____	_____	_____

Check Y for YES. CHECK N for NO.

High blood pressure	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Heart attack/Stroke	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Heart disease	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Asthma/Allergies	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Mental illness	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Auto-immune disease	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Diabetes Mellitus	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Osteoporosis	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Alzheimer's	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Tuberculoses (TB)	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N

Any other conditions?: _____

REVIEW OF SYSTEMS

Present weight: _____

Weight one year ago: _____ Recent weight gain, when & why: _____

Ideal weight: _____ Recent weight loss, when & why: _____

Please Mark ALL Symptoms that Apply: LEAVE BLANK if you've never had the symptom.
Check C if you have the problem CURRENT. Check P if you had the problem in the PAST.
Check Y for YES. Check N for NO.

Good energy: ☐Y ☐N

Fatigue: ☐Y ☐N

If fatigued, when is it the worst? ☐ Morning ☐ Afternoon ☐ Evening

If fatigued, can you do what you need to during the day?: ☐Y ☐N

SKIN

Lump:	☐ C	☐ P
Itchy:	☐ C	☐ P
Psoriasis/Eczema:	☐ C	☐ P
Skin cancer:	☐ C	☐ P

NECK

Pain:	☐ C	☐ P
Stiffness:	☐ C	☐ P
Swollen glands:	☐ C	☐ P
Tension:	☐ C	☐ P

HEAD

Headache:	☐ C	☐ P
Head injury:	☐ C	☐ P
Migraine:	☐ C	☐ P
TMJ	☐ C	☐ P

RESPIRATORY

Cough:	☐ C	☐ P
Tuberculosis:	☐ C	☐ P
Bronchitis:	☐ C	☐ P
Pneumonia:	☐ C	☐ P

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RESPIRATORY contd.

- Asthma: ☐ C ☐ P
- Wheezing: ☐ C ☐ P
- Painful breathing: ☐ C ☐ P
- Shortness of breath: ☐ C ☐ P
- Shortness of breath with exertion: ☐ C ☐ P

CARDIOVASCULAR

- High blood pressure: ☐ C ☐ P
- Low blood pressure: ☐ C ☐ P
- Murmurs: ☐ C ☐ P
- Arrhythmias: ☐ C ☐ P
- Palpitations: ☐ C ☐ P
- Chest pain: ☐ C ☐ P
- Leg/Feet swelling: ☐ C ☐ P

HEMATOLOGIC

- Anemia: ☐ C ☐ P
- Easy bruising: ☐ C ☐ P
- Easy bleeding: ☐ C ☐ P
- Transfusions: ☐ C ☐ P

ENDOCRINE

- Change in appetite: ☐ C ☐ P
- Thyroid problems: ☐ C ☐ P
- Difficulty maintaining weight: ☐ C ☐ P
- Diabetes: ☐ C ☐ P

MUSCULOSKELETAL

- Weakness: ☐ C ☐ P
- Arthritis: ☐ C ☐ P
- Stiffness: ☐ C ☐ P
- Leg cramps: ☐ C ☐ P
- Tremors: ☐ C ☐ P
- Joint pain: ☐ C ☐ P
- Muscle pain: ☐ C ☐ P
- Pain with sitting: ☐ C ☐ P

NERVOUS

- Blurry vision: ☐ C ☐ P
- Double vision: ☐ C ☐ P
- Sensitivity to light: ☐ C ☐ P

NERVOUS contd.

- Ringing in ears: ☐ C ☐ P
- Dizziness: ☐ C ☐ P
- Brain fog: ☐ C ☐ P
- Paralysis: ☐ C ☐ P
  - If so, what body part?

  _____
- Tingling/Numbness: ☐ C ☐ P
  - If so, where?:

  _____
- Radiculopathy: ☐ C ☐ P
  - If so, where?:

  _____
- Carpal tunnel syndrome: ☐ C ☐ P
- Fainting: ☐ C ☐ P
- Nerve pain: ☐ C ☐ P

FEMALE

- Hernia: ☐ C ☐ P
- Sexual active: ☐ C ☐ P
- Pain with intercourse: ☐ C ☐ P
- Vaginitis: ☐ C ☐ P
- Sexually transmitted infections: ☐ C ☐ P

Pregnancy:

- Gynecologic surgeries: _____
- Times pregnant: _____
- How many births: _____
  - Caesarian: _____
  - Vaginal: _____
- Miscarriages: _____
- Abortions: _____

MALE

- Testicular pain or swelling: ☐ C ☐ P
- Hernia: ☐ C ☐ P
- Sexually active: ☐ C ☐ P
- Prostate disease or symptoms: ☐ C ☐ P
- Sexually transmitted infections: ☐ C ☐ P
- Last prostate exam:

  _____

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