

NAME _____ BIRTH DATE _____ Age: ____ yrs.

SEX: M, F. ARE YOU RIGHT OR LEFT HANDED? (CIRCLE) RIGHT LEFT HEIGHT: _____ WEIGHT: _____

OCCUPATION: _____ ARE YOU WORKING NOW? (CIRCLE) YES NO

IF NO, WHEN DID YOU LAST WORK? _____

PRIMARY CARE (FAMILY) PHYSICIAN: _____

ARE YOU UNDER THE CARE OF ANY SPECIALISTS (PLEASE LIST): _____

WERE YOU REFERRED BY A PHYSICIAN? YES/ NO WHO? _____

CHIEF COMPLAINT:

WHAT ARE YOU HERE FOR? _____

PLEASE RATE YOUR PAIN ON A SCALE OF 1-10 (1-MILD, 10-UNBEARABLE) _____

HISTORY OF PRESENT ILLNESS:

WHEN DID THE PROBLEM START? _____ HOW DID IT START? (IE: INJURY, SLOWLY) _____

IF INJURY:

WAS IT RELATED TO A WORK ACCIDENT? YES NO

WAS IT RELATED TO A MOTOR VEHICLE ACCIDENT YES NO

DATE OF INJURY: _____

HAVE YOU HAD ANY TREATMENT FOR IT? (CIRCLE) YES NO.

MEDICATIONS TAKEN _____

PHYSICAL THERAPY? YES NO FOR ____ WEEKS. CORTISONE INJECTIONS? YES NO # OF INJECTIONS ____

HAVE YOU HAD ANY TESTS FOR THIS PROBLEM? YES NO

IF YES CIRCLE ALL THAT APPLY: X RAYS, CAT SCAN, MRI, NERVE STUDIES, BLOOD STUDIES

PAST MEDICAL HISTORY: DO YOU HAVE ANY OF THE FOLLOWING? (PLEASE CIRCLE)

DIABETES	THYROID DISEASE	HIGH BLOOD PRESSURE	ASTHMA	STROKE
ARTHRITIS	ULCERS	GOUT	BLEEDING TENDENCY	
LIVER DISEASE	HEARING IMPAIRED	HEART DISEASE	KIDNEY DISEASE	

CANCER: IF CIRCLED, PLEASE DESCRIBE: _____

PAST SURGICAL HISTORY: HAVE YOU HAD ANY SURGERY (OPERATIONS) AT ANY AGE? YES NO

IF YES PLEASE LIST WITH DATE: _____

MEDICATIONS: ARE YOU CURRENTLY TAKING ANY MEDICATIONS OR HERBAL SUPPLEMENTS? (INCLUDE OVER THE COUNTER) YES NO IF YES PLEASE LIST:

MEDICATION DOSE FREQUENCY

MEDICATION DOSE FREQUENCY

1. _____
2. _____
3. _____
4. _____

5. _____
6. _____
7. _____
8. _____

M.D. SIGNATURE

DATE (OVER)

ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS? (**CIRCLE**) YES NO. IF YES, WHAT REACTION TO WHAT MEDICATION DID YOU HAVE?

MEDICATION

REACTION

ARE YOU ALLERGIC TO LATEX (RUBBER PRODUCTS)? (**CIRCLE**)YES NO

SOCIAL HISTORY:

DO YOU SMOKE? YES NO IF YES HOW MUCH? _____ PACKS PER DAY
DO YOU DRINK ALCOHOL YES NO IF YES HOW MUCH? _____ PER DAY/WEEK
DO YOU TAKE ADDICTIVE DRUGS YES NO IF YES WHAT _____

FAMILY HISTORY: DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING. PLEASE CIRCLE ALL THAT APPLY:

DIABETES SICKLE CELL GOUT HEART DISEASE
CANCER ARTHRITIS HIGH BLOOD PRESSURE BLEEDING DISORDERS

OTHER KNOWN FAMILY DISEASE: _____

IS YOUR MOTHER ALIVE YES: AGE: _____ NO: AGE AT DEATH: _____
IS YOUR FATHER ALIVE YES: AGE: _____ NO: AGE AT DEATH: _____

REVIEW OF SYSTEMS: DO YOU HAVE ANY OF THE FOLLOWING. PLEASE CIRCLE ALL THAT APPLY

CONSTITUTIONAL SYMPTOMS: FEVER, WEIGHT CHANGE (INCREASE, DECREASE) # OF LBS ____ IN ____ MONTHS,
FATIGUE, APPETITE CHANGE (INCREASE, DECREASE)

EYES: DOUBLE VISION, BLURRING, TRAUMA, GLASSES

ENT & MOUTH: DEAFNESS, SINUSITIS, RINGING IN EARS, DIZZINESS

CARDIOVASCULAR: CHEST PAIN, PALPITATIONS, CALF PAIN WHILE WALKING (CLAUDICATION),
IRREGULAR HEART BEATS

RESPIRATORY: SHORTNESS OF BREATH, WHEEZING, COUGH, COUGHING BLOOD

GI: DIARRHEA, CONSTIPATION, ABDOMINAL PAIN, VOMITING, BLOODY STOOL

GU: HESITANCY, INCONTINENCE, PAIN ON URINATION, FREQUENT URINATION, MENSTRUAL PROBLEMS,
PREGNANCY

MS: OLD FRACTURE, SPRAINS, JOINT PAIN, JOINT SWELLING, ARTHRITIS, STIFFNESS, ATROPHY

SKIN: CHANGE IN COLOR OR TEMPERATURE, RASHES, LESIONS, SCARS, MASSES, ULCERS, DERMATITIS,
ECZEMA

NEURO: PROBLEMS WITH SPEECH OR SWALLOWING, STROKE, CHANGES IN SENSATION, SEIZURES, WEAKNESS,
VISUAL CHANGES, BALANCE, MEMORY, IN COORDINATION PROBLEMS, NUMBNESS TINGLING IN
EXTREMITIES

PSYCH: DEPRESSION, MOOD CHANGES, HALLUCINATIONS, SLEEP DISTURBANCES

ENDOCRINE: EXCESSIVE THIRST, HYPER/HYPOACTIVITY, GROWTH/HAIR CHANGES

HEMATOLOGIC/LYMPHATIC: BLEEDING TENDENCY, LYMPH NODE PAIN/ENLARGEMENT, ANEMIA

FAMILY MEMBER IN CASE OF EMERGENCY NAME _____

PHONE _____