Name: _____ Date:_____

Sex: (F) (M) Marital Status: (S) (M) (D) (W) Date of Birth: _____

Address: _____ City: _____ State:_____ Zip: _____

Phone: (H) _____ (C) _____ Email: _____
(by providing my email address, I authorize my doctor to contact me via the email address provided)

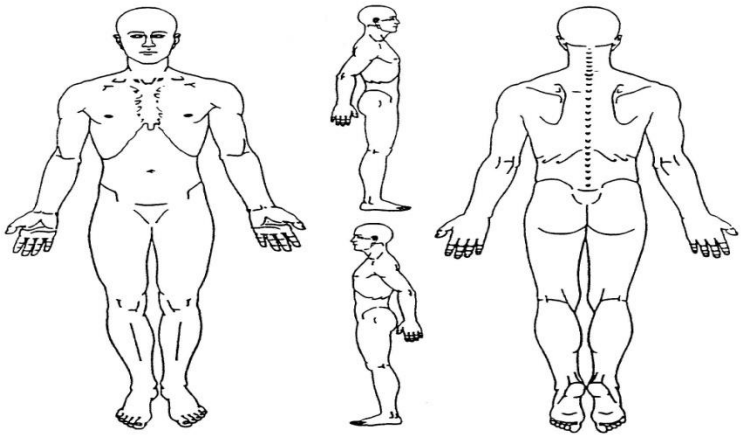
Occupation: _____ Employer: _____Work # _____

Spouse's Name: _____Spouse's DOB: _____ Spouse's Employer: _____

How did you hear about our office: _____

What is your primary complaint: _____

Indicate where you have pain or other symptoms:



Please circle how bad it hurts: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Most pain)

When did your symptoms begin? Month_____ Day_____Year_____

What caused your symptoms: ( ) Unknown ( ) Work related accident ( ) Motor Vehicle accident

( ) Other: _____

Please describe your complaint: Please circle all that apply:
Burning Sharp Stabbing Numbness Spasm Stiffness Dull Ache Throbbing Pins and Needles Swelling

Does the problem/pain radiate or travel to any other areas in your body? (Y) (N)
If so where? _____

How often do you experience your symptoms? Please circle one:
Occasional (20%) Intermittent (40%) Frequent (60%) Constant (80%)

My symptoms are:
Worse in the morning Worse at night Worse throughout the day Does not change

What makes your problem better? Please circle.
Ice Heat Medication Massage Nothing Sitting Standing Lying Other:_____

What makes your problem worse? Please circle.
Bending Bowel movements Coughing Daily routine Getting up Lifting lying down Pulling Pushing
Reading Sitting Sleeping Sneezing Standing Turning head Walking Working Other: _____

Other doctors seen for this condition: Please circle.
Hospital Urgent Care Medical Physician Chiropractor Massage Therapist Physical Therapist Other:_____
Treatment given: _____

Name of Primary Physician: _____

Current Medications: _____

Habits:
( ) Former Smoker ( ) Current Smoker Packs/Day _____ ( ) Never Smoker
( ) Alcohol Drinks/Week _____
( ) How many days do you exercise each week: _____

Please list any drug allergies: _____

Surgeries: Put year performed if applicable:
Ankle: _____ Back: _____ Cosmetic or Augmentation: _____ Elbow: _____ Foot: _____ Hand: _____
Head: _____ Hip: _____ Knee: _____ Neck: _____ Shoulder:_____ Wrist: _____ Heart: _____
GI: _____ Urinary-Genital: _____ Other Surgeries: _____

Hospitalizations and Injuries (if any broken bones which ones) _____

List any cancer you've had: _____

Family History:

	Hypertension:	Diabetes:	Cancer/Type
Mother:	( )	( )	_____
Father:	( )	( )	_____
Sibling:	( )	( )	_____

Are you Pregnant? ( ) Y ( ) N ( ) N/A
Do you have a pacemaker? ( ) Y ( ) N

Patient Name **Date**

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Circulatory Health			Seizures		
	Past	Present	Shingles		
Anemia			Stomach Ulcers		
HIV/AIDS			Urinary Tract Infections		
Hemophilia			Thyroid Dysfunction		
Hepatitis			**Musculoskeletal Health**		
Hypertension				Past	Present
Hypotension			Ankylosing Spondylitis		
Asthma			Osteoarthritis		
Bronchitis			Rheumatoid Arthritis		
COPD			Gout		
Emphysema			Herniated Disk		
Pneumonia			Lyme Disease		
Tuberculosis			Multiple Sclerosis		
Raynaud's Phenomenon			Muscular Dystrophy		
Sinus Infections			Numbness/Tingling in feet		
Stroke			Numbness/Tingling in hands		
ENDO, GI, NEURO			Osteoporosis		
	Past	Present	Parkinson's Disease		
Autoimmune Disorder			Polio		
Dermatitis			TMJ		
Lupus			**Mental Health**		
Bladder Disease				Past	Present
Candida			Bipolar Disorder		
Chicken Pox			Eating Disorders		
Chronic Fatigue Syndrome			Restless Leg Syndrome		
Crohn's Disease			Substance Abuse		
Diabetes			Anxiety Disorder		
Epilepsy			Depression		
Fibromyalgia			Sleep Disorders		
Gall Bladder Problems			PTSD		
Headaches			**Sensory Health**		
Cluster Headaches				Past	Present
Migraine Headaches			Ear ringing		
Sinus Headaches			Glaucoma		
Stress-induced Headaches			Macular Degeneration		
Tension Headaches			Meniere's Disease		
Incontinence			Vertigo		
IBS			Cataract		
Kidney Disease			Hearing loss		
Liver Problems					
Liver Disease					
Measles					
Mumps					