Current Health Form

If more than one issue, complete another form

Name______________________________ Birthdate ____/____/____ Date ____/____/____

What is your Primary Reasons for today's visit? □ Wellness / Maintenance Visit (If yes, no need to complete.)

□ I have a body issue. (Complete **all** questions below)

Select one health issue then complete all questions about that one selected health issue-

□ Headaches
□ Allergies
□ Sinus Issues
□ Cold/Flu
□ Stress
□ Ear Infections/Ache
□ Digestive__________
□ Neck
□ Mid Back
□ Lower back
□ Pelvis
□ Hip
□ Extremity_______
□ Other __________

Is it on the: □ Left Side □ Right Side □ Centered □ Other ___________

Does it travel? □ No □ Yes If yes, where? ____________________________________

Is this condition: □ New □ Flare-Up □ Chronic condition?

When did it start? ___/___/___

What caused it? □ Unknown __________________________________

How many times does it bother you, circle DAY or WEEK

□ Constant
□ 0-25% per **day or week**
□ 26-50% per **day or week**
□ 51-75% per **day or week**
□ 76-100% per **day or week**

Describe the discomfort:

□ Ache
□ Sharp
□ Burning
□ Tingling
□ Numb
□ Tight
□ Pulling
□ Other ____________

Discomfort Scale: **No Pain** = 0 1 2 3 4 5 6 7 8 9 10 = **Unbearable Pain**

What makes it worse? 1. ________________ 2. _________________

What makes it better? 1. ________________ 2. _________________

Has it changed your daily activities? □ N □ Y How? 1. _______________ 2. _______________

Other treatments/Doctors seen for this? 1. ________________

Mark an **X** on areas bothering you on the diagram
Mark an → if it travels