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Name:____ **Date**:____________________

Presenting Condition

Please describe the problem/s you are currently experiencing:____

____

____

How long have you had this condition?____

Is your condition getting: □ worse □ same □ better

Describe the pain you are feeling: □ sharp □ dull □ stabbing □ throbbing □ shooting □ burning

_ other: (*please describe*)____

When does it bother you? □ work □ sleep □ sitting □ standing □ walking □ other:________________

____

What relieves the pain? □ work □ sleep □ sitting □ standing □ walking □ other: ________________

____

What seemed to be the initial cause:____

____

____

List any other doctors seen and list treatment received and results obtained: ________________

____

____

Pain Scale

Please circle the number that best describes your pain at its **LEAST**

0	1	2	3	4	5	6	7	8	9	10
None										Severe

Please circle the number that best describes your pain at its **WORST**

0	1	2	3	4	5	6	7	8	9	10
None										Severe

List all medications/supplements you are taking:____

____

____

please complete the reverse side of this form

Name:____ **Date:**____________________

Past Health History

List all surgeries you have had and list dates: ____

Have you ever been in an automobile accident? ☐ yes ☐ no When? __________________________

Describe Injury: ____

Have you ever had an industrial injury for which you received treatment? ☐ yes ☐ no

When?____________________ Describe:______________________________

Please check the conditions you have or have had:

☐ Alcoholism	☐ Cold sores	☐ Heart disease	☐ Miscarriage	☐ Rheumatic fever
☐ Allergies	☐ Diabetes	☐ Hepatitis	☐ Multiple sclerosis	☐ Stroke
☐ Anemia	☐ Eczema	☐ Herpes	☐ Mumps	☐ Thyroid disease
☐ Appendicitis	☐ Edema	☐ High Cholesterol	☐ Numbness/tingling	☐ Tuberculosis
☐ Arteriosclerosis	☐ Emphysema	☐ HIV/AIDS	☐ Osteoporosis	☐ Ulcers
☐ Arthritis	☐ Epilepsy	☐ Hypoglycemia	☐ Pace maker	☐ Venereal disease
☐ Bronchitis	☐ Goiter	☐ Influenza	☐ Parkinson's disease	☐ __________
☐ Cancer	☐ Gout	☐ Malaria	☐ Pneumonia	☐ __________
☐ Chicken pox	☐ Heartburn	☐ Measles	☐ Polio	☐ __________

Are you pregnant? ☐ no ☐ yes Due date:____________________

Do you have any other health issues or concerns that we should be made aware of? ____________________

Have you...	**Yes**	**No**	**If yes, explain briefly**
...been hospitalized in last 5 years?	☐	☐	____________________
...had any broken bones?	☐	☐	____________________
...had any sprains or strains?	☐	☐	____________________
...ever used orthotics?	☐	☐	____________________

How is most of your day spent? ☐ standing ☐ sitting ☐ other: ____________________

What hobbies, activities, sports do you participate in?______________________________

How many times a day/week/month & how long do you participate in the above activity? ____________________

When was your last physical exam? __________

Family History age health problems or cause of death

	age	cancer	diabetes	heart disease	neurologic disorders	rheumatoid arthritis	other
mother:	_____	☐	☐	☐	☐	☐	☐ __________
father:	_____	☐	☐	☐	☐	☐	☐ __________
mother's mother:	_____	☐	☐	☐	☐	☐	☐ __________
mother's father:	_____	☐	☐	☐	☐	☐	☐ __________
father's mother:	_____	☐	☐	☐	☐	☐	☐ __________
father's father:	_____	☐	☐	☐	☐	☐	☐ __________
brothers:	_____	☐	☐	☐	☐	☐	☐ __________
	_____	☐	☐	☐	☐	☐	☐ __________
sisters:	_____	☐	☐	☐	☐	☐	☐ __________
	_____	☐	☐	☐	☐	☐	☐ __________
children:	_____	☐	☐	☐	☐	☐	☐ __________
	_____	☐	☐	☐	☐	☐	☐ __________

Name:______________________________ **Date:**______________________

HEALTH REVIEW

Mark [x] for current problems and [_] for past history and indicate age when it occurred:

SKIN, HAIR, NAILS

- ☐ eczema
- ☐ itchy skin
- ☐ dry scalp
- ☐ oily scalp
- ☐ rough, scaly skin
- ☐ dry skin
- ☐ oily skin
- ☐ psoriasis
- ☐ yellow skin
- ☐ bruise easily
- ☐ paper thin nails
- ☐ pale skin
- ☐ nail biting
- ☐ baldness

EYES

- ☐ vision problems
- ☐ eye pain
- ☐ eyes fatigue easily
- ☐ excessive tearing
- ☐ lack of tearing
- ☐ light bothers eyes

EARS

- ☐ loss of hearing
- ☐ pain in ears
- ☐ ringing in ears
- ☐ vertigo

NOSE /SINUSES

- ☐ unusual nasal discharge
- ☐ nose bleeds
- ☐ nasal obstruction
- ☐ frequent colds
- ☐ any trauma to nose
- ☐ loss of sense of smell
- ☐ sinusitis

MOUTH AND THROAT

- ☐ pain of mouth
- ☐ pain of throat
- ☐ bleeding gums
- ☐ cavities
- ☐ dentures
- ☐ difficulty swallowing
- ☐ changes in voice
- ☐ abscessed teeth

RESPIRATORY

- ☐ shortness of breath
- ☐ can't breath lying down
- ☐ chest pain
- ☐ chronic cough
- ☐ difficulty breathing
- ☐ coughing up blood/phlegm
- ☐ wheezing

GASTROINTESTINAL

- ☐ poor appetite
- ☐ excessive hunger
- ☐ difficulty swallowing
- ☐ indigestion
- ☐ can't eat some foods
- ☐ nausea & vomiting
- ☐ liver trouble
- ☐ abdominal pain
- ☐ change in bowel habit
- ☐ diarrhea
- ☐ constipation
- ☐ hemorrhoids

GENITOURINARY

urination is:

☐ frequent ☐ normal ☐ infrequent

the amount is:

☐ high ☐ normal ☐ low

- ☐ bladder infection
- ☐ kidney infection/stones
- ☐ lack of bladder control
- ☐ overnight more than twice
- ☐ more than 8x in 24hrs
- ☐ blood in urine
- ☐ decreased flow/force
- ☐ pain on urination
- ☐ difficulty starting urination
- ☐ abnormal intense desire to urinate
- ☐ dribbling

WOMEN ONLY

- ☐ painful period
- ☐ spotting
- ☐ vaginal discharge
- ☐ premenstrual symptoms
- ☐ irregular periods
- ☐ lumps in breast
- ☐ hot flashes
- ☐ menopause

Are you pregnant? ☐ yes ☐ no

pregnancies_______ # deliveries________

SOCIAL HISTORY

	none	light	mod	heavy
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Coffee/ Tea	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Water	☐	☐	☐	☐
Family stress	☐	☐	☐	☐
Job stress	☐	☐	☐	☐

My diet is ☐ balanced ☐ not balanced

How do you like your work?

- ☐ very much
- ☐ it's okay
- ☐ I hate it

GENERAL

- ☐ allergies
- ☐ depression
- ☐ dizziness
- ☐ fatigue
- ☐ headaches
- ☐ irritability
- ☐ loss of sleep
- ☐ nervousness
- ☐ crave salts
- ☐ crave sweets
- ☐ tremors
- ☐ weight gain
- ☐ weight loss

please complete the reverse side of this form

Name: ________________________ **Date:** ______________________

Mark [x] for current problems and [_] for past history and indicate age when it occurred:

CARDIOVASCULAR

☐ general swelling
☐ palpitation
☐ hypertension
☐ irregular heart beat
☐ slow heart beat
☐ pounding heart beat
☐ heart "jumps"
☐ rapid heart beat
☐ ringing in ears
☐ heart attack
☐ high blood pressure
☐ low blood pressure
☐ fainting
☐ hardening of the arteries
☐ dizziness with nausea
☐ dizziness without nausea
☐ blurred vision
☐ cold hands and/or feet
☐ areas of numbness
☐ blue or purple skin
☐ blue or purple nailbeds
☐ chest pain
☐ areas of muscle weakness
☐ diabetes
☐ stroke
☐ pain over the heart
☐ poor circulation
☐ swelling in face
☐ swelling in legs
☐ swelling around eyes

VERTEBROBASILAR

☐ double vision
☐ loss of coordination
☐ irregular muscle movement
☐ arthritis of the neck
☐ previous neck/head injury
☐ loss of memory
☐ high blood pressure
☐ chronic headaches
☐ periods of blindness in one eye
☐ areas of numbness
☐ blood vessel disease (phlebitis, etc.)
☐ check if you are a female age 20-46
☐ check if you smoke
☐ check if any of your family members have had a stroke
☐ check if you are taking aspirin or blood thinners
☐ check if you are taking birth control pills

MUSCULOSKELETAL SYSTEM

HEAD

☐ frequent headaches
☐ severe headaches
☐ head feels heavy
☐ vertigo
☐ light-headedness
☐ loss of smell
☐ loss of taste
☐ loss of balance
☐ dizziness

MID BACK

☐ mid back pain
☐ pain between shoulders
☐ dull ache
☐ pain from front to back
☐ pain over kidney area
☐ muscle spasms in mid back

SHOULDERS

☐ pain in shoulders (R) (L)
☐ pain across shoulders
☐ tension in shoulders
☐ muscle spasms in shoulders
☐ can't raise arm
☐ above shoulder level
☐ over head

ARMS & HANDS

☐ pain in upper arm
☐ pain in forearm
☐ pain in hands
☐ swollen joints in fingers
☐ sensation of pins & needles
☐ pain in fingers
☐ loss of grip strength
☐ fingers go to sleep
☐ sharp stabbing pain

NECK

☐ limited neck movement
☐ pain in neck
☐ stiff neck
☐ swelling in neck
☐ neck pain with movement
☐ pinched nerve in neck
☐ neck feels out of place
☐ hands cold
☐ muscle spasms in neck
☐ grinding sounds in neck
☐ popping sounds in neck

LOW BACK

☐ low back pain
☐ muscle spasms in low back
☐ low back feels out of place

HIPS, LEGS & FEET

☐ pain in buttocks
☐ pain down leg
☐ knee pain
☐ leg cramps
☐ pins & needles in legs
☐ numbness in leg
☐ numbness in toes
☐ cold feet
☐ swollen ankles
☐ swollen feet

Please check the <u>best</u> answer (choose one please)

I remember important things in my life by:

☐ what I see
☐ what I hear
☐ what I feel

The primary reason I brush my teeth is to

☐ avoid tooth decay and gum disease
☐ make sure I have healthy teeth and gums

When I make a decision I generally:

☐ gather facts and weigh the evidence
☐ make the right choice instantly
☐ consult my friends and family
☐ depend upon how I feel about it