LAST NAME: _____ MR NUMBER: _____

PATIENT INFORMATION

FIRST NAME:_____ MIDDLE NAME: _____

LAST NAME: _____

DOB: _____ GENDER: _____

SSN: _____

HOME ADDRESS:

STREET:_____

CITY:_____ STATE: _____ ZIP: _____

MAILING ADDRESS: IF SAME AS ABOVE, CHECK HERE _____

STREET: _____

CITY:_____ STATE: _____ ZIP: _____

PHONE NUMBER:

CELL: _____HOME: _____WORK: _____

EMAIL: _____

EMPLOYER: _____

REFERRAL FROM:_____

PRIMARY CARE PHYSICIAN: _____

LATE CANCELLATION/NO SHOW POLICY

A 24-hour cancellation policy applies to your appointment. You may leave a phone message at any time of day to cancel your appointment, and it will date and time stamp your call. If you are unable to cancel your appointment 24-hours in advance, a cancellation charge for the full treatment fee will apply.

Please do your best to arrive on time for your appointment. If you are delayed, please contact us as soon as possible; we will do our best to accommodate you, depending on schedule availability.

LAST NAME: _____ MR NUMBER: _____

MEDICAL HISTORY

Please complete this form to the best of your ability, and put "N/A" if a section is not applicable to your health.

Date of Visit: _____ Date of your last physical examination: _____

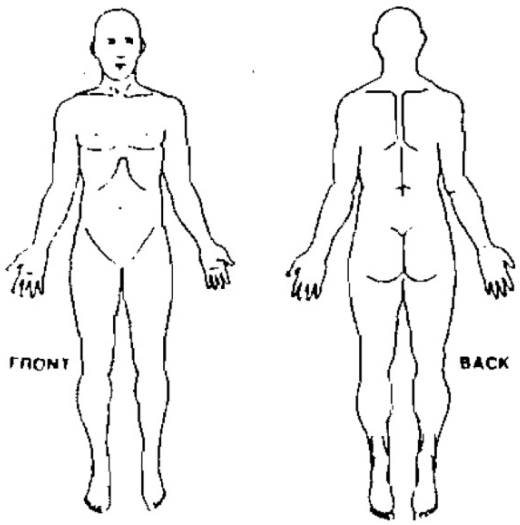
Height: _____ Weight: _____

Major Concern for Visit:

_____

_____

PLEASE MARK YOUR AREAS OF PAIN



When did you first have symptoms of your major concern? _____

How long have you had this condition? _____

How would you describe your symptoms? (e.g. if pain, is it sharp, stabbing, burning, pins and needles, cramping, tight) _____

If presenting with pain, how would you rate your pain? (Rate 0-10, 0 being no pain and 10 being the worst pain of you can imagine) _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

How often do your symptoms occur: Constantly Present _____
Or Intermittently Present (please specify when) _____

Overall, are your symptoms improving? ___ Worsening? ___ Staying the same? ___

LAST NAME: _____ MR NUMBER: _____

What previous medications or treatments have you tried for your condition? Have you had acupuncture, chiropractor, physical therapy, TENS unit, or other modalities?

_____

_____

How does this condition affect your functional life? (Rate 0-10, 0 being no affect and 10 being significant affect) _____

Are you able to do your activities of daily living (e.g. clean the house, laundry)? ____

(Y/N) Would you like to exercise more? _____ (Y/N) Explain further:

_____

_____

What would be your goal from your visit and treatment?

_____

_____

Allergies to Medications: _____

Environmental or Food Allergies: _____

Vaccination History: Routine _____ Modified Course _____

Medications / Drugs / Herbs Currently Taking:

Please indicate dose and how often you are taking. Please bring an attached list if you need more room to complete this.

Previous Surgeries: Please also indicate year of procedure

_____

_____

_____

Scars: Please list all scars from accidents or surgeries

_____

Family History: _____

_____

_____

Social History:

Alcohol use: (Y/N) _____Tobacco use: (Y/N) _____ Recreational drug use: (Y/N) _____

Marital Status (circle): Single Married Divorced Widowed

Children: (Y/N – list number) _____ Pets: (Y/N) _____

LAST NAME: _____ MR NUMBER: _____

Medical History / Review of Systems: Please circle the items that are pertinent to your medical history. Please fill in the blanks where indicated.

Head/Eyes/Ears/Nose/Throat: Headaches Tinnitus Dizziness Syncope
Visual changes TMJ (jaw pain) Colds/Upper Respiratory Infection
Sinus infections Strep Throat Dental Pain or Dental Concerns Ear pain/infections
Hearing loss

Cardiac: High Blood Pressure Chest pain Palpitations Skipped beats
Orthostatic changes Flushing Sweating Swelling in legs
Waking up in the middle of the night from difficulty breathing

Respiratory: Wheezing Shortness of Breath Cough Asthma Snoring Sleep Apnea
Falling asleep while driving or watching TV Smoking Seasonal allergies

Digestion: Changes in appetite Nausea Vomiting GERD/Dyspepsia/Acid Reflux
Changes in bowel function (constipation, loose stools, incontinence) Stomach pain
Abdominal bloating Eating disorder/anorexia/bulimia Liver disease/Cirrhosis
Weight gain Weight loss Sugar cravings Salt cravings

- How many meals per day do you eat? _____
- Do you ever rush through meals? _____
- How much water do your drink every day? _____

Urine: Urinary urgency or frequency Pain or burning with urination Blood in urine
Urinary Tract Infection Kidney stones Incontinence

Musculoskeletal: Weakness/falling/tripping Muscle pains Joint pains

Skin: Dryness Rashes Eruptions Eczema Scars

Hematology/Vascular: Blood Thinner medications Aspirin Coagulopathy
Easy bruising Frequent nosebleeds Jehovah's witness Cold hands/cold feet

Neurologic: Balance or gait disturbance Weakness/falling/tripping Numbness or tingling Bowel or bladder incontinence Seizures Vertigo Strokes

Endocrine: Diabetes Hyperthyroid Hypothyroid

Psychology: Depression Anxiety PTSD Bipolar Low Energy High Energy

- Have you been in the care of a mental health counselor or psychiatrist in the past? (if so, for how long) _____

Reproductive Male: Impotence Premature ejaculation Prostate problem Low Libido
Reproductive Female: Premenstrual symptoms Irregular menses Painful periods
Heavy bleeding Menopausal symptoms Pregnancy Birth Control Low libido

Sleep:

- How many hours of sleep do you get? _____
- Do you feel refreshed or tired in the morning? _____
- Do you have difficulty with falling asleep? _____ Do you have frequent awakenings at night? _____