Patient Name _____ **Date of Birth** _____

Age _____ Handedness (R or L) _____

Referring Doctor:_____

Chief Complaint (What is bothering you the most)_____

_____

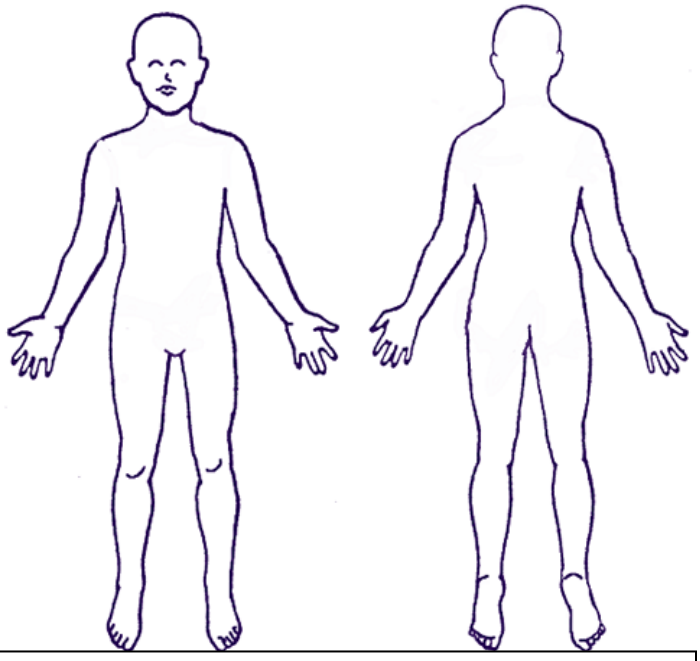
1) How long has this been bothering you? _____

2) What makes this WORSE? _____

3) What makes this BETTER? _____

4) CHOOSE ONE: Neck **OR** Back

Pain	**Percentage**
Neck Pain	_____%
Arm Pain	_____%
Added =	**100 %**
Back Pain	_____%
Leg Pain	_____%
Added =	**100%**



5) Please **mark the diagram** to the right to demonstrate where your pain is located.

6) Please list all your previous treatments (Physical Therapy, steroids, injections, Accupunture, Chiropractic, etc.)

Past Personal/Family Medical History	Yes	You	Mother	Father	**if yes, please explain**
Ever diagnosed with Cancer?					
Diabetes					
High Blood Pressure					
Bleeding Problems					
Clotting Problems					
Kidney Problems					
Heart Problems					
Lung Problems					
Liver Problems					

Please list **any** other medical conditions for yourself or parents:

Patient Name:_____Date of Birth:_____

REVIEW OF SYSTEMS

Please mark and (X) if any of the following apply to you recently:

1. Constitutional	**recently**	**8. Musculoskeletal**	**recently**
Weight Loss		Generalized Muscle Weakness	
Weight Gain		Fractures	
Fever		Muscle Tears	
Fatigue		Joint pain	
2. Eyes		**9. Skin**	
Double Vision		Masses	
Spots Before Eyes		Rash	
Blurry vision		Ulcers	
3. ENT/Mouth		**10. Neurological**	
Ear Aches		Headache	
Ringing in Ears		Backache	
Sinus Problems		Neck Pain	
Sore Throat		Limb Pain	
Mouth Sores		Dizziness	
Dental Problems		Seizures	
4. Cardiovascular		Numbness	
Painful Breathing		Trouble Walking	
Chest Pain		Leg or back pain with walking	
Difficult Breathing on Exertion		Limb weakness	
Swelling of Legs		**11. Psychiatric**	
Palpitations of Heart		Depression	
Blood clots in legs/lungs		Anxiety	
5. Respiratory		**12. Endocrine**	
Wheezing		Dry Skin	
Spitting up Blood		Abnormal Thirst	
Shortness of Breath		Hot Flashes	
Cough, Chronic		**13. Hematologic/Lymphatic**	
6. Gastrointestional		Bruises, Frequent	
Diarrhea, Frequent		Cuts Do Not Stop Bleeding	
Bloody Stool		Enlaraged Lymph Nodes	
Nausea/Vomiting		Heparin Therapy	
Constipation		Coumadin Therapy	
Stomach		Lovenox Therapy	
7. Genitourinary		Greenfield Filter	
Blood in Urine			
Pain with Urination			
Urgency			
Frequency of Urination			
Incomplete Emptying			
Stress Incontinence			
Abnormal Periods			
Erectile Dysfunction			
Painful Intercourse			

Reviewed:_____Date:_____

Patient Name:_____D.O.B._____

PERSONAL INFORMATION

Occupation:_____

Marital Status:_____

Number of Children:_____

Who do you live with:_____

Do you smoke: [ ]YES [ ] NO How many packs per day?:_____For how long?_____

If you don't smoke now, did you in the past? [ ]YES [ ] NO When did you quit?_____

Do you drink: [ ]YES [ ] NO How may per week?:_____

Height:_____ Weight:_____

Pharmacy(Name and phone number):_____

CURRENT MEDICATIONS

Drug Name/strength	Dosage	Drug Name/strength	Dosage

DRUG ALLERGIES

[ ] NKDA

Drug Name & Type of Reaction	Drug Name & Type of Reaction

SURGERIES

Reason	Date	Reason	Date