Your Name_____ DOB _____ Today's Date_____

Symptoms and Present State of Health

Present Complaint/Reason for seeking care in this office _____

When did your problem begin? _____ How did your problem/complaint begin? _____

How would you describe your discomfort? (circle all that apply) Sharp Dull Ache Burning Pinching Stiff

Constant Intermittent Other _____

Do your symptoms radiate, shoot or travel in your body? Where? _____

Are you experiencing numbness/tingling in any area of your body? Where? _____

Since it began, is your problem: Same Better Worse

What aggravates or makes your problem worse? _____

What lessens or makes your problem better? _____

Is this problem worse during certain times of the day? _____

Does this condition interfere with (circle all that apply) Work Sleep Routine Other_____

Please list any other health practitioners you have seen for this condition and when seen

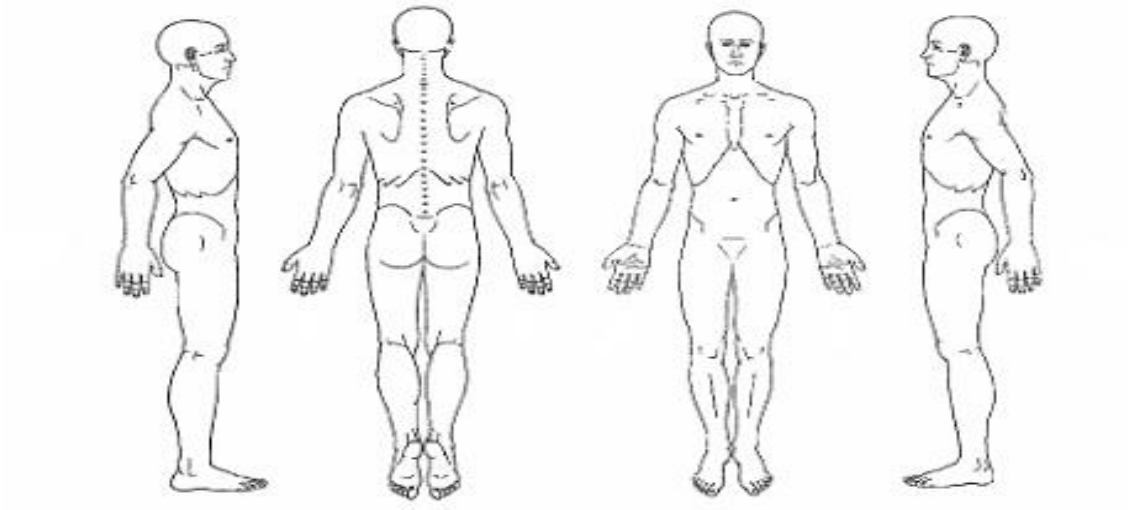
_____

Any home remedies _____ Do they help? _____

Please rate your pain by circling the number on the scale

(No complaint/ pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain imaginable)

Using the symbols below, mark on the pictures where you feel the pain.



Are you under medical care for any condition? If yes, please explain _____

What medications are you taking and for how long? _____

Please list any surgeries you have had and when _____

Is there a family history of: Heart Disease Arthritis Cancer Diabetes Stroke Other

If yes, please explain _____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__Convulsions
__Dizziness
__Fainting
__Loss of Balance
__Fatigue
__Depression
__Headache
__Nervousness
__Irritability
__Tension
__Numbness

MUSCLES & JOINTS
__Low Back Pain
__Pain between shoulders
__Neck problems
__Arm or Hand problems
__Leg or Foot problems
__Jaw/TMJ problems
__Painful joints
__Stiff joints
__Sore muscles
__Weak muscles
__Walking problems
__Sprains/Strains
__Broken Bones

CARDIOVASCULAR
__High Blood Pressure
__Heart Attack
__Pain over the heart
__Poor Circulation
__Rapid Heart Rate
__Slow Heart Rate
__Strokes/TIA's
__Swelling in Ankles
__Varicose Veins
__Cold Feet/Hands

MENTAL/EMOTIONAL
__Anxiety
__Depression
__Anger/Aggression
__Attention Deficit
__Other_____

EAR/NOSE/THROAT
__Earache
__Enlarged Thyroid
__Frequent Colds
__Hay Fever
__Nasal Blockage/Deviated Septum
__Nose Bleeds
__Pain Behind Eyes
__Poor Vision
__Sinusitis
__Sore Throats
__Tonsilitis

GASTRO-INTESTINAL
__Stomach upset
__Frequent Belching/Gas
__Colon Problems
__Constipation
__Excessive Hunger
__Excessive Thirst
__Gall Bladder/Liver problems
__Nausea
__Abdominal Pain
__Ulcer
__GERD/Reflux/Heartburn
__Poor Appetite
__Poor Digestion
__Foods Not Fully Broken Down
__Vomiting
__Vomiting Blood
__Black Stool
__Bloody Stool
__Coating on Tongue
__Foul Breath/Halitosis
__Diarrhea
__IBS
__Crohn's
__Alternate Constipation/Diarrhea
__Loss of Smell or Taste
__Overly Sensitive to Smells

RESPIRATORY
__Asthma
__Chronic Cough
__Emphysema
__Spitting Blood
__Spitting Phlegm
__Allergies

GENITO-URINARY
__Blood in Urine
__Frequent Urination
__Urinary Tract Infections
__Kidney Infection
__Painful Urination
__Prostate Problems
__Loss of Bowel or Bladder Control

SKIN CONDITIONS
__Acne
__Boils
__Bruise Easily
__Eczema/Rash/Dermatitis
__Hives
__Itching frequently
__Sensitive Skin
__Dry Skin
__Hair Loss
__Too much hair

WOMEN
__Birth Control_____
__Cramps/Backache with Menstrual Cycle
__Excessive Flow
__Irregular Cycle
__Hot Flashes
__Miscarriage
__Infertility
__Painful Periods
__Vaginal Discharge
__Breast Pain
__Breast Lumps
__Fibrocystic Breasts
__# of Pregnancies _____
__# of Children_____
__Menopause, when started _____

MEN
__Testicular Problems/Pain
__Erection Difficulties
__Prostate Problems

HABITS
__Smoking, what kind and how much _____
__Alcohol drinks/week_____
__Caffeine-Coffee/Tea/Energy Drinks Amount_____
__Stress Level Low Moderate High
__Exercise _____ Days/week What type of exercise_____ ___Ounces of pure water/day

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

PATIENT SIGNATURE_____ **DATE** _____