

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? _____

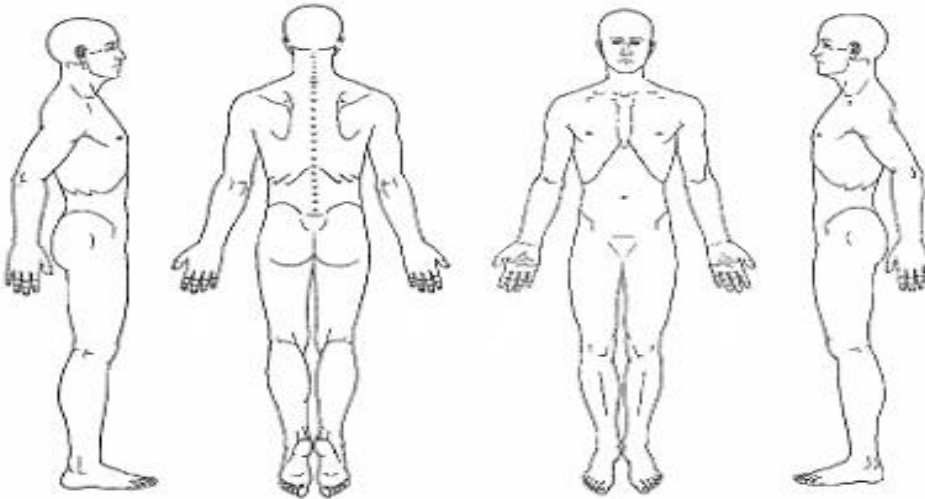
Does this condition interfere with (circle all that apply) Work Sleep Routine Other _____

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 symptoms.



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 _____

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 _____

EAR/NOSE/THROAT

- Earache
- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage/Deviated Septum
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

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

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 _____