Patient Name: _____ **Patient #:** _____ **Date:** _____

WHAT BROUGHT YOU INTO THE OFFICE

If you have no symptoms or complaints and are here for wellness services, please check here _____.

CURRENT HEALTH CONDITION (why are you here today): _____

_____

_____

When did this condition start? _____

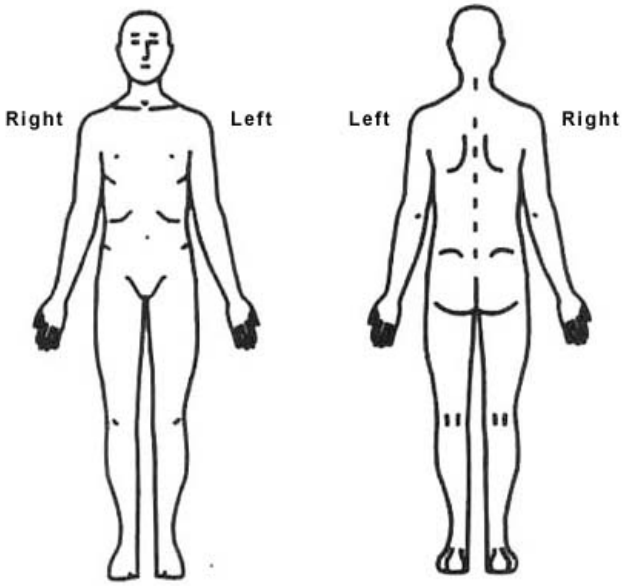
Has it ever occurred before? o Yes o No When? _____

Is the condition: o Auto Related o Work Related o No Injury o Other

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT:

Use the letters below to indicate the type and location of your sensations right now:

DA=Dull Ache SA=Sharp Ache B=Burning N=Numbness/Tingling P=Pins & needles
S=Stabbing T=Throbbing



Patient Name_____ Patient #: _____

Since the problem(s) started, it is… o Getting Better o About the Same o Getting Worse

What makes the pain/problem worse?

_____

_____

The pain interferes with: o Walking o Sitting o Hobbies o Socializing o Sleep o Work o Personal Care o Lifting o Reading o Concentration o Driving o Sex Life

What helps the pain/problem?

_____

_____

Please list other practitioners you have seen for this issue.

_____

Are you currently taking any prescription medications? o Yes o No If yes, please mark or list

o Allergy medications o Anti-depressants o Blood Pressure Medications o Insulin o Muscle Relaxers o Nerve Pills o Pain Killers o Other _____

_____

Are you wearing any of the following? o Heel Lifts o Innersoles o Arch Supports o Orthotics

Have you had recent blood work? o Yes o No If yes, when _____

YOUR HEALTH BELIEFS

What tools have you used to try to reduce stress?

_____

_____

_____

What bad habits do you need to release?

_____

_____

_____

How do you currently support your health?

_____

_____

_____

Patient Name: _____ Patient #: _____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

REVIEW OF SYSTEMS-Please fill out all of the sections, even if "DENY".

Constitutional: I… ○ Deny any constitutional issue (s)

○ Chills ○ Daytime Somnolence (Drowsiness) ○ Fatigue ○ Fever ○ Night Sweats

○ Weight gain ○ Weight Loss

Eyes/Vision: I…○ Deny any Eyes/Vision issue (s)

○ Blindness ○ Blurred Vision ○ Cataracts ○ Change in Vision ○ Double Vision

○ Eye Pain ○ Field Cuts (visual field defect) ○ Glaucoma ○ Itching (around eyes) ○ Photophobia

○ Tearing ○ Wears Glasses and/or Contact lenses

Ears, Nose and Throat: I…○ Deny any Ears, Nose and Throat Issue (s)

○ Bleeding ○ Dental Implants ○ Dentures ○ Difficulty Swallowing ○ Discharge

○ Dizziness ○ Ear Drainage ○ Ear Infection (s) ○ Ear Pain ○ Fainting

○ Headaches ○ Head Injury (history of) ○ Hearing Loss ○ Hoarseness ○ Loss of Smell

○ Nasal Congestion ○ Nose Bleeds (frequent) ○ Post Nasal Drip ○ Runny Nose ○ Sinus Infections

○ Snoring ○ Sore Throats (frequent) ○ Tinnitus ○TMJ Problems

Respiration: I…○ Deny any Respiratory Issue (s)

○ Asthma ○ Cough ○ Coughing up blood ○ Shortness of breath ○ Sputum Production ○ Wheezing

Cardiovascular: I…○ Deny any Cardiovascular Issue (s)

○ Angina ○ Claudication (leg pain/achiness) ○ Heart Murmur ○ Heart Problems

○ Orthopnea (difficulty breathing while lying down) ○ Palpitations ○ Swelling of Legs

○ Paroxysmal Nocturnal Dyspnea (waking @ night with shortness of breath) ○ Ulcers ○ Varicose Veins

○ Shortness of breath with exertion or exercise

Gastrointestinal: I…○ Deny any Gastrointestinal Issue (s)

○ Abdominal pain ○ Belching ○ Black, Tarry Stools ○ Constipation ○ Diarrhea

○ Difficulty Swallowing ○ Heartburn ○ Hemorrhoids ○ Indigestion ○ Jaundice

○ Nausea ○ Rectal Bleeding ○ Abnormal Stool ○ Vomiting Blood ○ Vomiting

Female: I…○ Deny any Female Issue (s)

○ Birth Control Therapy ○ Breast Lumps/Pain ○ Burning Urination ○ Cramps ○ Frequent Urination

○ Hormone Therapy ○ Irregular Menstruation ○ Urine Retention ○ Vaginal Bleeding/Discharge

Patient Name: _____ Patient #: _____

REVIEW OF SYSTEMS (continued)

Male: **I…o Deny any Male Issue (s)**

o Burning Urination o Erectile Dysfunction o Frequent Urination o Hesitancy/Dribbling

o Prostate Problems o Urine Retention

Endocrine: I…o Deny any Endocrine Issue (s)

o Cold Intolerance o Diabetes o Excessive Appetite o Excessive Hunger o Excessive Thirst

o Frequent Urination o Goiter o Hair Loss o Heat Intolerance o Unusual Hair Growth

o Voice Changes

Skin: I…o Deny any Skin Issue (s)

o Changes in Nail Texture o Changes in Skin Color o Hair Growth o Hair Loss o Hives

o Itching o Paresthesia o Rash o History of Skin Disorders o Skin Lesions/Ulcers o Varicosities

Nervous System: I…o Deny any Nervous System Issue (s)

o Dizziness o Facial Weakness o Headaches o Limb Weakness o Loss of Consciousness

o Loss of Memory o Numbness o Seizures o Sleep Disturbance o Slurred Speech o Stress

o Strokes o Tremors o Unsteadiness of Gait

Psychologic: I…o Deny any Psychologic Issue (s)

o Anhedonia (inability to enjoy life) o Anxiety o Appetite Change (s) o Behavioral Change (s)

o Bipolar Disorder o Confusion o Convulsions o Depression o Insomnia

o Memory Loss o Mood Change (s)

Allergy: I…o Deny any Allergy Issue (s)

o Anaphylaxis (history of) o Food Intolerance o Itching o Nasal Congestion o Sneezing

Hematology: I…o Deny any Hematologic Issue (s)

o Anemia o Bleeding o Blood Clotting o Blood Transfusion (s) o Bruises Easily o Fatigue o Lymph Node Swelling

---

SOCIAL HISTORY

Alcohol: o Never o Social Consumption only o Beer o Liquor o Wine; amt_____ o day o week o month

Diet (please mark all that apply): o Low Fat o High Fiber o High Protein o High Salt o Low Calorie

o Low Carb o Low Fiber o Low Salt o Low Sugar o Paleo

o Pre-packaged meal plan (WeightWatchers, Nutrisystem, etc.)

Drugs: o Deny any illegal drug use o Deny use of IV drugs o Have not used drugs since_____

o Have used drugs for _____

Tobacco: o Deny any tobacco use o Live with a smoker o Quit smoking, when _____

Patient Name: _____ Patient #: _____

PATIENT HEALTH HISTORY-

Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness: I…o Deny any Childhood Illness (es)

o ADD o Allergies/Hayfever o Asthma o Atopic Dermatitis (Eczema) o Bedwetting

o Cerebral Palsy o Chicken Pox o Depression o Diabetes o Ear Infection

o Fetal Drug Exposure o Food Allergies o Headaches o Hepatitis o HIV

o Measles o Seizure disorder o Mumps o Scoliosis o Rash

o Sickle Cell Anemia o Spina Bifida o Other: _____

Adult Illnesses: I…o Deny any Adult Illness (es)

o Alzheimers o Anemia o Arthritis o Asthma o Cancer

o Chicken Pox o Crohn's/Colitis o CRPS (RSD) o CVA (stroke) o Cystic Kidney disease

o Depression o Diabetes (insulin) o Diabetes (non) o Ear infections o Emphysema

o Eye Problems o Fibromyalgia o Heart Disease o Hepatitis o HIV

o Hypertension o Influenzal pneumonia o Liver Disease o Lung disease o Lupus (discoid)

o Lupus (systemic) o Multiple sclerosis o Parkinson's disease o Pleurisy o Pneumonia

o Psychiatric problems o Scoliosis o Seizure disorder o Shingles o STD's (unspecified)

o Suicide attempt (s) o Thyroid Problems o Vertigo

Surgeries: I…o Deny any Surgery (ies)

Please list what and when:

_____

_____

_____

_____

Injuries: I…o Deny any Injury (ies)

Please list what and when:

_____

_____

_____

Non-drug Allergies: I…o Deny any Non-Drug Allergy (ies)

o Animals o Dairy o Eggs o Food Colorings o Mold o Pollen o Wheat (Gluten)

o Other (please be specific): _____

Patient Name: _____ Patient #: _____

FAMILY HISTORY **Condition (please be specific)**

Father ○ Alive ○ Deceased ○ No significant disease ○ Has/Had: _____

Mother ○ Alive ○ Deceased ○ No significant disease ○ Has/Had: _____

Paternal Grandfather ○ Alive ○ Deceased ○ No significant disease ○ Has/Had: _____

Paternal Grandmother ○ Alive ○ Deceased ○ No significant disease ○ Has/Had: _____

Maternal Grandfather ○ Alive ○ Deceased ○ No significant disease ○ Has/Had: _____

Maternal Grandmother ○ Alive ○ Deceased ○ No significant disease ○ Has/Had: _____

Son (s) ○ Alive ○ Deceased ○ No significant disease ○ Has/Had: _____

Daughter (s) ○ Alive ○ Deceased ○ No significant disease ○ Has/Had: _____

Brother (s) ○ Alive ○ Deceased ○ No significant disease ○ Has/Had: _____

Sister (s) ○ Alive ○ Deceased ○ No significant disease ○ Has/Had: _____

Is there anything else you would like us to know, which we have not covered?

_____

_____