FAMIILY MEDICAL HISTORY			Relationship to you				Relationship to you
Alcohol abuse	Yes	No	_____	Heart Attack	Yes	No	_____
Asthma	Yes	No	_____	High Blood Pressure	Yes	No	_____
Anxiety	Yes	No	_____	High Cholesterol	Yes	No	_____
Back Problems	Yes	No	_____	Kidney Disease	Yes	No	_____
Bleeding Disorder	Yes	No	_____	Liver Disease	Yes	No	_____
Cancer	Yes	No	_____	Osteoporosis	Yes	No	_____
Depression	Yes	No	_____	Scoliosis	Yes	No	_____
Diabetes	Yes	No	_____	Sick Cell Anemia	Yes	No	_____
Epilepsy/Seizures	Yes	No	_____	Stroke	Yes	No	_____
Glaucoma	Yes	No	_____	Thyroid Problem	Yes	No	_____
Gout	Yes	No	_____	Tuberculosis	Yes	No	_____

Other:_____

PAST SURGICAL HISTORY (Please list all surgeries/procedures and dates that you have had since childhood and indicate left or right when appropriate)

_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

Occupation_____
Smoking Status □ Never □ Former □ Current everyday □ Current somedays
Have smoked since what age? _____
Smoking / How much? _____
Chewing Tobacco □ Yes □ No
Alcohol Intake □ None □ Yes, how much _____type of alcohol_____
Caffeine Intake □ None □ Yes, how many cups a day _____
Illicit Drugs □ Yes □ No If yes what type:_____
Have you ever been treated for drug, alcohol or prescription abuse in the past? □ Yes □ No
Exercise Level □ Never □ Yes what type and how often

_____
Hand Dominance □ Right □ Left □ Both
Education:_____
Live alone or with others? □ Live Alone □ With Others □ Married □ Single □ Divorced □ Child

Chief Complaint/ History of Present illness:
What are you being seen for today? _____
Left_____Right_____N/A_____
Is it due to an injury? Yes No Were you hurt at work? Yes No Were you in a car accident? Yes No
How long has your problem or pain been present?_____
Date of injury?_____

Previous Health care providers you have seen for this problem?

_____

Injury / Pain to? Left Right Both
Arm Shoulder Elbow Wrist Hand Leg Knee Ankle Foot Neck Back
Other_____

How did your pain begin?
□ Abruptly, getting better □ Gradually, getting better
□ Abruptly, remaining the same □ Gradually, remaining the same
□ Abruptly, and getting worse □ Gradually, getting worse

Which best describes the quality of your current pain complaint (check all that apply)
□ Sharp □ Burning □ Throbbing □ Shooting □ Aching □ Stabbing □ Dull □ Numb □Tingling
Other_____

How often do you have pain?
□ Constantly □ Intermittently(several times per day)
□ Occasionally(several times per week) □ Rarely(a few times per month)

What makes your pain WORSE (check all that apply)?
□ Sitting □ Coughing □ Sneezing □ Looking up
□ Lifting □ Twisting □ Bending Forward □ Looking down
□ Standing □ Walking □ Bending Backward □ Weather Changes
□ Lying down □ Exercise □ Stress □ Bowel movements
□ Looking over your shoulder(R or L)
□ Other_____

What makes your pain BETTER (check all that apply)?
□ Standing □ Lying down □ Heat
□ Sitting □ Cold □ Nothing
□ Exercise/activity □ Rest
□ Medications- if yes which one(s):_____
□ Other:_____
□ Nothing

Is your pain associated with other symptoms?
□ Weakness – if yes, where?_____
□ Numbness – if yes, where?_____
□ Bowel or bladder changes – if yes describe:_____
□ Fine motor control problems(ie. Buttoning your shirt, using a pencil, etc)
□ Other:_____

Please check off any of the following treatments that you have had for your current symptoms:

Treatment	**Did it help (yes / no)?**		**Treatment**	**Did it help (yes / no)?**	
□Physical therapy	Yes	No_____	□Psychiatric Care	Yes	No
□Chiropractic care or manipulations	Yes	No_____	□TENS Unit	Yes	No
□Psychological Care	Yes	No	□Accupuncture	Yes	No
□Pain Program / Pain Clinic	Yes	No _____	Other:_____		
□Medications (duration)_____					

Patient name:_____

REVIEW OF SYSTEMS (Please check symptoms you are having today)

CONSTITUTIONAL: □ no problem
□ poor appetite □ weight loss Amount_____ □ weight gain Amount_____ □ fevers □ night sweats

□ other _____

EYES: □ No problem
□ visual changes □ double vision □ color vision changes □ eye irritation □ other_____

EAR, NOSE, THROAT: □ No problem
□ hearing loss □ ringing in ears □ nosebleeds □ other _____

CARDIOVASCULAR: □ no problem
□ chest pain □ swelling in legs/feet □ palpitations □ fainting □ shortness of breath □ other _____

RESPIRATORY: □ no problem
□ chronic cough □ shortness of breath □ wheezing □ home oxygen □ other _____

GASTROINTESTINAL: □ no problem
□ nausea/vomiting □ change in bowel movement □ bloody/black tarry stools □ constipation □ abdominal pain
□ diarrhea □ other _____

GENITOURINARY: □ no problem
□ incontinence of urine □ changes in urinary pattern □ difficulty with erections □ kidney stones □ blood in urine

□ other _____

MUSCULOSKELETAL: □ no problem
□ limited range of motion_____ □ muscle joints/aches □ muscle loss where?_____ □ stiffness in Joints □ other _____

INTEGUMENTARY (SKIN): □ no problem
□ rash □ tumors □ discoloration □ itching □ eczema/psoriasis □ changes in moles □ other _____

NEUROLOGIC : □ No problem
□ Poor appetite □ frequent/severe headaches □ weakness-where?_____ □ difficulty walking □ poor memory
□ difficulty chewing/swallowing □ poor coordination □ dizziness □ recent falls □ other_____

PSYCHIATRIC: □ no problem
□ frequent sadness/depression □ anxiety □ loss of interest □ excessive worry □ low energy level □ suicidal thoughts

□ other_____

ENDOCRINE: □ no problem
□ glucose/sugar changes □ excessive urination □ excessive thirst □ heat/cold intolerance □ other _____

HEMATOLOGIC : □ no problem
□ easy bruising □ Anemia (low blood count) □ trouble controlling bleeding □ other _____

ALLERGIC/ IMMUNOLOGIC : □ no problem
□ difficulty breathing □ swelling pain at groin, axilla, neck □ rash/itch to materials, food, animals □ other_____

Patient signature_____ **Provider**_____ **Date**_____