

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

D.O.B: \_\_\_\_\_ S.S # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: M F Marital Status: Single Married Divorced Widowed

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_

How were you referred to our office: \_\_\_\_\_

**Review of Systems:** Mark (c) for current problems, check and indicate age when you had any of the following:

**General:**

- Depression
- Dizziness
- Fatigue
- Headaches
- Loss of Sleep
- Tremors
- Weight Loss/Gain
- Alcoholism
- Appendicitis
- Asthma
- Cancer
- Diabetes
- Gout
- Miscarriage
- Multiple Sclerosis
- Numbness/Tingling
- Osteoporosis

**Muscle Joint:**

- Arthritis/Rheumatism
- Bursitis
- Muscle Weakness
- Low Back Pain
- Mid Back Pain
- Neck Pain
- Joint Pain

**Gastrointestinal/Genitourinary:**

- Abdominal Pain
- Bloody or Tarry Stool
- Colitis/Crohn's
- Constipation
- Gallbladder Trouble
- Hernia
- Bed-Wetting
- Bladder Infection
- Kidney Problems

**Cardiovascular/Respiratory:**

- High/Low Blood Pressure
- Pain over heart
- Swelling of Ankles
- Chest Pain
- Shortness of Breath
- Stroke

**Women Only:**

Menstrual Flow:

Reg. Irreg. Pain/Cramps

Date - 1<sup>st</sup> day of last Period: \_\_\_\_\_

Are You Pregnant? Yes, No

If yes, How many months? \_\_\_\_\_

How many children do you have? \_\_\_\_\_

Birth control Method: \_\_\_\_\_

**Past Health History:**

Have you...  
 Been hospitalized in the last 5 years **Yes No Explain:** \_\_\_\_\_  
 Had any broken bones **Yes No Explain:** \_\_\_\_\_  
 Had any strains or Sprains **Yes No Explain:** \_\_\_\_\_  
 How is most of your day spent? **Standing Sitting Other:** \_\_\_\_\_  
 How old is your mattress? \_\_\_\_\_  
 When was your last physical exam? \_\_\_\_\_

**Habits:**

Alcohol:	None	Light	Moderate	Heavy
Tobacco:	None	Light	Moderate	Heavy
Drugs:	None	Light	Moderate	Heavy
Exercise:	None	Light	Moderate	Heavy
Sleep:	None	Light	Moderate	Heavy
Soft Drinks/Caffeine:	None	Light	Moderate	Heavy
Salty Foods:	None	Light	Moderate	Heavy
Water:	None	Light	Moderate	Heavy

Do you have any other health issues or concerns that our staff should be aware of? \_\_\_\_\_

**Family History:** If any blood relative has had any of the following conditions, please check and indicate which relative(s)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Cancer        | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> High Cholesterol    |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema     | <input type="checkbox"/> Multiple Sclerosis  |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Osteoporosis        |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke              |

**Patient Medication List:** Please list clearly all medications and supplements and why you are taking them.

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**Patient Current Complaint:**

Give a brief description of the problem you are currently experiencing: \_\_\_\_\_

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How long have you had this condition: \_\_\_\_\_ Is it getting worse? YES NO

What seems to be the initial cause: \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

Describe the type of pain you are having, Dull, Sharp, Shooting, etc.: \_\_\_\_\_

What activities are your complaints interfering with? \_\_\_\_\_

What do you hope to achieve with receiving care in our office? \_\_\_\_\_

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