

**CURRENT MEDICAL PROBLEM**

Name of Patient \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Today's Date \_\_\_\_\_  
Birth date \_\_\_\_\_

**Consulting Doctor** (Name of doctor who sent you here): \_\_\_\_\_

**Primary Care Doctor:** \_\_\_\_\_

Please tell us why you are here today: \_\_\_\_\_

Where is your pain (problem): \_\_\_\_\_

Was there an accident or injury: \_\_\_\_\_

Does this condition affect your Right Side Left Side Is this work related? No Yes

When did this start: \_\_\_\_\_

What is the pain like: \_\_\_\_\_

What makes it worse: \_\_\_\_\_

What makes it better: \_\_\_\_\_

Is it getting: Better Worse

What other symptoms do you have: \_\_\_\_\_

Have you had any treatment for this to this date: No Yes By whom: \_\_\_\_\_

If so, please indicate treatment by marking the appropriate box:

Therapy Injections Surgery Hospitalization Chiropractic

How has this been evaluated:

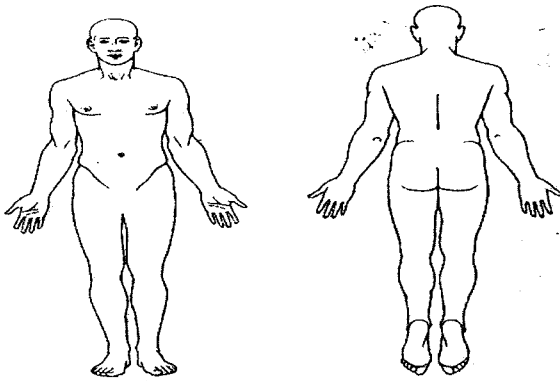
X-rays Cat Scan MRI EMG's

Have you tried any medication for this problem? No Yes Please list: \_\_\_\_\_

**Diagram**

(mark parts of your body where you feel the problem. Use the appropriate symbols indicated below)

Your Approx. Height \_\_\_\_\_



Right                      Left                      Left                      Right  
Front                      Back

Ache \_\_\_\_\_                      Stabbing \_\_\_\_\_  
Swelling \_\_\_\_\_                      Numbness \_\_\_\_\_  
Pins/Needles \_\_\_\_\_                      Popping, Cracking, Grinding \_\_\_\_\_

Severity of pain: 10 being worst

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1 2 3 4 5 6 7 8 9 10

For office use only:		
Date _____	WT _____	
P _____	T _____	IN _____

**I certify to the best of my knowledge that the above information is correct**

Patient/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

**I have reviewed and agree with the findings as noted** Physicians Signature: \_\_\_\_\_

**PAST MEDICAL INFORMATION**

Name of Patient \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Today's Date \_\_\_\_\_  
Birth date \_\_\_\_\_

List Medical Conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Your Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic or sensitive to any medications or other substances?  Yes  No  Metals  Latex  
If so, please list allergy and reaction: \_\_\_\_\_  
\_\_\_\_\_

**Past Surgical History:** Have you ever been operated on for any condition?  Yes  No

Procedure	Date	Procedure	Date
<input type="checkbox"/> Orthopedic	_____	<input type="checkbox"/> Hernia Repair	_____
<input type="checkbox"/> Tonsillectomy	_____	<input type="checkbox"/> Gall Bladder	_____
<input type="checkbox"/> Cataracts	_____	<input type="checkbox"/> Hysterectomy	_____
<input type="checkbox"/> Appendectomy	_____	<input type="checkbox"/> C Section	_____
<input type="checkbox"/> Bladder /or Prostate	_____	<input type="checkbox"/> Cardiac/Bypass Surgery	_____
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Other	_____

Have you ever had general anesthesia?  NO  YES Have you or your family had any problems with anesthesia?  NO  YES

**Review of Symptoms:** Are you (or the child) currently having or have had problems with your (check boxes that are positive and explain):

Constitutional:	NO	YES	Fatigue <input type="checkbox"/>	Fever <input type="checkbox"/>	Weight Loss <input type="checkbox"/>	Other: _____	
Eyes:	NO	YES	Blurred vision <input type="checkbox"/>	Glasses <input type="checkbox"/>	Other: _____		
Ears, Nose, Throat:	NO	YES	Congestion <input type="checkbox"/>	Hearing Loss <input type="checkbox"/>	Other: _____		
Lungs, Breathing:	NO	YES	Shortness of breathe <input type="checkbox"/>	Wheezing <input type="checkbox"/>	Cough <input type="checkbox"/>	Other: _____	
Heart:	NO	YES	Chest Pain <input type="checkbox"/>	Irregular heartbeat <input type="checkbox"/>	Other: _____		
Gastrointestinal:	NO	YES	Nausea <input type="checkbox"/>	Vomiting <input type="checkbox"/>	Constipation <input type="checkbox"/>	Diarrhea <input type="checkbox"/>	Other: _____
Bladder:	NO	YES	Incontinence <input type="checkbox"/>	Urinary tract infection <input type="checkbox"/>	Difficulty urinating <input type="checkbox"/>	Other: _____	
Endocrine:	NO	YES	Diabetes <input type="checkbox"/>	Thyroid problems <input type="checkbox"/>	Other: _____		
Musculoskeletal:	NO	YES	Joint pain <input type="checkbox"/>	Leg pain <input type="checkbox"/>	History of broken bones <input type="checkbox"/>	Other: _____	
Bleeding problems:	NO	YES	Blood Clots/DVT <input type="checkbox"/>	Prolonged bleeding after cut/injury <input type="checkbox"/>	Other: _____		
Neurological:	NO	YES	Numbness/tingling <input type="checkbox"/>	Dizziness <input type="checkbox"/>	Headaches <input type="checkbox"/>	Frequent falls <input type="checkbox"/>	Other: _____
Integumentary:	NO	YES	Rashes <input type="checkbox"/>	Skin disorders <input type="checkbox"/>	Other: _____		
Psychiatric:	NO	YES	Change in mood <input type="checkbox"/>	Change in sleep patterns <input type="checkbox"/>	Other: _____		
Immunologic/Allergic:	NO	YES	Asthma <input type="checkbox"/>	Chronic rashes <input type="checkbox"/>	Hay fever <input type="checkbox"/>	Other: _____	

**Social History**  
Occupation: \_\_\_\_\_  
Do you currently smoke?  No  Yes  
Have you ever smoked?  No  Yes If yes, how long ago did you quit? \_\_\_\_\_  
Do you consume any alcohol?  No  Yes If yes, how often? \_\_\_\_\_  
Single  Married  Divorced  # of children \_\_\_\_\_

Is there a **family history** of: High Blood Pressure  Heart Disease  Diabetes  Cancer  Hyperthermia  None

**I certify to the best of my knowledge that the above information is correct:** \_\_\_\_\_ Reviewed: \_\_\_\_\_  
Patient/Guardian Signature \_\_\_\_\_  
Date: \_\_\_\_\_  
**I have reviewed and agree with the findings as noted** Physicians Signature: \_\_\_\_\_