NAME:	DATE:

DOB:________________ Age:________ Gender: __________

Your Current Condition

What are your primary complaints/reasons for today's visit?
1.) 2.)

Is it new or chronic?

1.) 2.)

Where is it located? On Left side, right side, both?
1.) 2.)

Describe how it feels (ache, sharp, numb, pressure, tight/stiff, tingling, burning, etc.):

1.) 2.)

How bad is your pain on an average day? (1-10 scale)

1.) 2.)

Is it constant or does it come and go?

1.) 2.)

When did it begin? (Approximate Date)

1.) 2.)

Do you know how it started / cause?

1.) 2.)

What makes it feel better or worse? Check below:

	Better	Worse	Same		Better	Worse	Same
Heat				Exercise			
Ice				Stretching			
Rest				Pain Medications**			

**List names, dosages, and frequency of pain medications used (including over-the-counter medications in medication section):

Prior Treatment

	Better	Worse	Same		Better	Worse	Same
Osteopathic Treatment				Chiropractic			
Acupuncture				Counseling			
Massage				Biofeedback			
PT/OT				Other			

Prior Procedures/Equipment

	Better	Worse	Same		Better	Worse	Same
Surgery				Injections			

Orthotics/Lifts				Braces			

In the space below, please provide details about treatments **including healthcare provider, diagnosis, approximate treatment dates, plan, imaging and lab studies.**

____

____

____

Activities of Daily Living

Circle the following activities you can do WITHOUT assistance:

Eat   Bathe   Use the Toilet   Dress   Get up from bed or chair

Additional Questions About Your Complaints

Circle "Y" for Yes and "N" for No when answering the following questions related to your current complaints:

- Do you have a recent history of cancer or unexplained weight loss? Y N
- Do you have a current infection or immunosuppression? Y N
- Have you had a motor vehicle accident or industrial injury recently? Y N
- Have you had a major fall recently? Y N
- Do you have numbness along the inside of your legs? Y N
- Have you had a sudden onset of bladder dysfunction (i.e. urine retention, increased frequency or incontinence)? Y N
- Have you had a recent onset of fecal incontinence (loss of bowel control)? Y N
- Have you had major motor weakness (loss of strength or ability to walk)? Y N
- Have you had similar episodes of your current complaints before? Y N
  If the answer is yes, please list previous dates for the past 2 years (or as far back as you can remember______________________________
- Have you had any diagnostics studies/imaging done? Y N
  If the answer is yes, please provide us with the imaging report or a report from the ordering physician that includes a summary of the findings.

Employment

Circle your work status: Full-Time or Part-Time without Limits
Full-Time or Part-Time with Limits   Retired

List your type of work, including job tasks that may affect the management of your complaints

(sitting all day, computer use, etc.): ______________________________

If you are not working or limited in your work capacity, please list the length of time for work limitations: ______________________________

Is there any Workers' Compensation or litigation involvement? Y N

Allergies

No Known Drug Allergies (NKDA)

For each allergy, please list 1) Name of Allergen

2) The Location and the Reaction

a. Skin (local rash, rash all over, itchiness, patchy swelling, facial swelling, hives)
b. Local (runny nose, cough, conjunctivitis/eye inflammation)
c. Abdominal (pain/cramping, bloating/gas, vomiting, diarrhea, nausea)
d. Systemic/anaphylactic (shortness of breath, wheezing, tongue swelling, difficulty speaking or swallowing, dizziness/light headedness, loss of consciousness, chest pain, irregular heartbeat, fast heartbeat, slow heartbeat, breathing distress)

3) Severity of the reaction (very mild, mild, moderate, severe)

Food allergy examples: Dairy, egg, wheat/gluten, peanuts, other nuts, shellfish, soy
Environmental allergy examples: dust, pollen, animal dander, dust mites, insect stings, mold, latex.

IF NOT ENOUGH SPACE, PLEASE PROVIDE A SEPARATE SHEET

Allergen **Drug** **Food** **Environmental**	**Location** **Skin** **Local** **Abdomen** **Systemic**	**Reaction** **(See above)**	**Severity** **very mild** **mild** **moderate** **severe**	**Status** **ACTIVE (A)** **Inactive (I)**

Medications/Supplements

No Medications No Vitamins/ Supplements

IF NOT ENOUGH SPACE, PLEASE PROVIDE A SEPARATE SHEET

Name	Dosage	Frequency

Review of Systems

Please check if you have any of the following:

General: Weight gain Weight loss Change in appetite Fatigue Weakness Sleep disturbance Night Sweats Irritability Indifference Fever Chills

HEENT: Headaches Migraines **Head Injuries** **Head pain** Eye pain Vision Changes Eye discharge Dry Eye Eye disease Hearing Loss Tinnitus Ear Pain Sore Throat Sinus Congestion Post Nasal Drip Nasal Congestion Hoarseness Difficulty Swallowing

Skin: Itching Burning Rashes Lumps Tumors Warts Changes in Moles Dry skin

Cardio: Chest Pain Palpitations Cold Extremities Pain in Extremities Foot/Ankle Swelling

Respiratory: Cough Wheeze Use an Inhaler Shortness of Breath w/ Activity Shortness of Breath at Rest

Gastrointestinal: Nausea Vomiting Abdominal Pain Heartburn/Reflux Change in Bowel Habits Diarrhea Constipation Excessive Gas Bloating Food Intolerance

Urinary: Burning/Pain with Urination Flank Pain Blood in Urine Urinary Frequency/Urgency Incontinence Difficulty Urinating

Female: Decreased Sense of Wellbeing Decreased Mental Sharpness Cold Intolerance Decreased Energy Decreased Sexual Desire Indecisiveness Painful Intercourse Nipple Discharge Menstrual Irregularity Decreased Flow Bloating PMS Menstrual Cramps Pelvic Pain Vaginal Discharge Vaginal Bleeding Post Menopause Hot Flashes Excessive Thirst Change in Hair Quality Easy Bruising Fertility Problems

Male: Decreased Sense of Wellbeing Decreased Energy Penile Discharge Prostate Swelling Decreased Mental Sharpness Loss of Muscle Mass Cold Intolerance Erectile Dysfunction Ejaculation Dysfunction Painful Intercourse Decreased Sexual Desire Excessive Thirst Change in Hair Quality Easy Bruising Fertility Problems

Musculoskeletal: Joint Pain Swollen Joints Muscle Pain Red Joints Stiff Joints Weakness Muscle Cramps/Spasms

Nervous System: Headaches Numbness Tingling Radiating Pain Seizures Tremors Loss of Coordination Fainting Dizziness/Vertigo Change in Taste or Smell Abnormal Gait Poor Memory Poor Concentration Brain Fog

Psychological: Anxious/Worried Irritable Anger/Rage Hyperactive Obsessive/Compulsive Depressed Mood Feeling Sad or Hopeless Poor Focus Inability to Concentrate

Add Other Complaints Not Specified Above: ____

Past Medical History

Please check if you have **ever** had any of the following:

COVID Neurological Disease Headache Traumatic Brain Injury Stroke/TIA Vertigo Restless Leg Syndrome Multiple Sclerosis Seizures Neuropathy Bell's Palsy Trigeminal Neuralgia Meniere's Disease Depression Anxiety GERD/Reflux ADD/ADHD PTSD Fibromyalgia Chronic Fatigue Hearing Loss Rheumatoid Arthritis Osteoarthritis Osteoporosis Osteopenia Torn Ligaments Sprains Anatomical Short Leg Scoliosis Sciatica Bursitis

Tendonitis Plantar Fasciitis TMJ Dysfunction Herniated Disc DDD DJD Spinal Stenosis Spondylolisthesis Carpal Tunnel Syndrome Bruxism Respiratory Disease Asthma COPD Chronic Bronchitis Pulmonary Embolism Pneumonia CHF Heart Disease High Blood Pressure Heart Attack Angina Arrhythmia High Cholesterol Heart Murmur Gastrointestinal Disease Liver Disease, Hepatitis IBS Inflammatory Bowel Disease HIV, Infectious Disease Lyme Disease Shingles HSV (Herpes) Diabetes Thyroid Disease Obesity Hiatal Hernia Sexual Dysfunction Urinary Incontinence Kidney Disease Endometriosis Substance Abuse Cancer Anemia Enlarged Prostate Kidney Stones Menopause PMS/PMDD Chronic Pain Measles Mumps Rubella Varicella Pertussis Polio Rheumatic Fever Allergies Autism Constipation Feeding Problems Sensory Integration Disorder Otitis Media Sinusitis Vaccine Reactions Other: ____

Trauma History

Trauma Type Details and approximate dates **No Trauma History**

Trauma Type	Details and approximate dates
Head Trauma/Concussion:	
Motor Vehicle Accidents:	
Sports Injuries:	
Bone Fractures:	
Dental Work:	
Birth Trauma:	
Emotional Trauma:	
Other Trauma:	

Past Surgical History

None
Craniotomy Myringotomy/Ear Tube Nasal Surgery Sinus Surgery Nasal Septal Repair Tonsillectomy Adenoidectomy Oral Surgery Coronary Artery Bypass Graft Angioplasty-Stent

Gastric Bypass/Banding Cholecystectomy Splenectomy Umbilical Hernia Repair Appendectomy Colectomy Breast Surgery Mastectomy Hysterectomy Oophorectomy Laparoscopic Surgery Cesarean Section Plastic Surgery Radiation/Seeds TURP Inguinal Hernia Repair Discectomy/Laminectomy Spinal Fusion Kyphoplasty Carpal Tunnel Surgery Ligament/Tendon Repair Joint Replacement Total Hip Replacement Total Knee Replacement Arthroscopic Surgery ORIF for Bone Fracture Other____

Family History

Have any blood relatives ever been diagnosed with any of the following? Unknown

Glaucoma Hearing Loss Depression Alcohol/Substance Abuse Arthritis Back Pain Heart Disease High Cholesterol High Blood Pressure Stroke Seizures Diabetes Obesity Thyroid Disease Osteoporosis Autoimmune Disease Cancer Bleeding Disorder Asthma Allergies Lyme/Co Infection Disease ADD/ADHD Anxiety Fibromyalgia/CFIDS Other

Social History

Tobacco Use: Do you use tobacco? Yes No Have you ever used tobacco? Yes No

Chew - #/day _______ Pipe - #/day ______ Cigars #/day _____Cigarettes – Pks/day _______

Year started ________ # of Years _________ Year Quit _________

Alcohol Use (Circle One): Never Occasional Moderate Weekly Use Heavy Daily Use Not Currently

#drinks/week _______

Marijuana Use (Circle One): Never Occasional Moderate Weekly Use Heavy Daily Use Not Currently

# of times per week _______

Illicit Drug Use (Circle One): Never Occasional Moderate Weekly Use Heavy Daily Use Not Currently

# of times per week _________ Type of Drug _________

Do you use caffeine? Yes No Not currently How much/how often_______________________

Residence (Circle One): Home Independent Home Dependant on Family Assisted Living Nursing Home None

I am: right-handed left-handed Sleep/rest (# of hours/quality) ___________________________________

Martial Status (Circle One): Single Married Divorced Partner Widowed

Please circle: There are: pets smokers woodstove in the home. Quality of home life______________

Physical Activity (type/frequency) ___________________________Stretching (type/frequency) _______________

Diet (circle) Organic Gluten Free Dairy Free Vegetarian Keto Other Fluid intake_____________________________

Do you use artificial sweeteners? Yes No Hobbies/recreation_____________________________________

Reproductive History

Female:

Total # of Pregnancies ____ # of Full Term ____ # of Pre-Term ____ # of Miscarriages/Abortions ____

# of living children ____ # of Deceased____ # of C-sections/dates ____________# of Vaginal deliveries____

Complications ____

Male: # of living children ________ # of Deceased ________