Medical History

Patient Name: _____ Date: _____

What is your chief complaint? _____

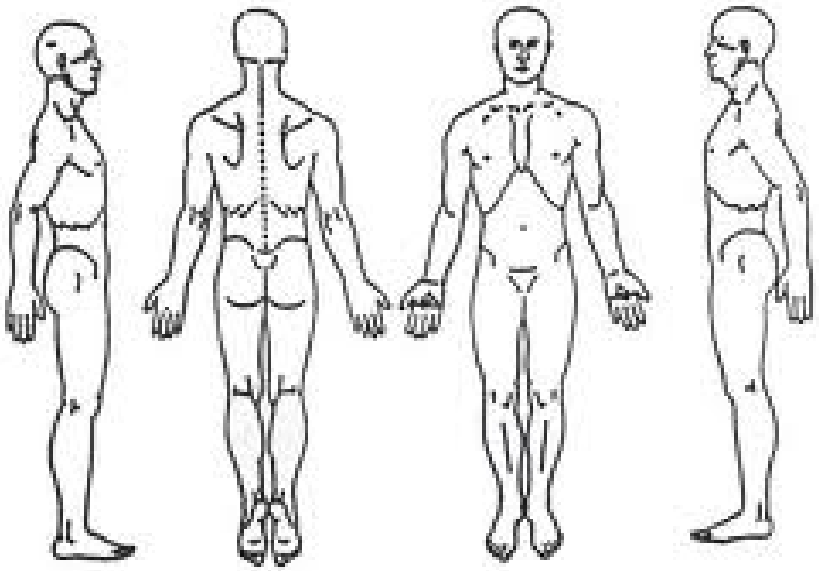
List any other complaints? _____

History of present illness

1. Date of injury or when symptoms began:_____
2. Is this condition due to an: ___auto accident ___work injury ___unknown cause ___illness ___other accident (explain):_____
3. Are the symptoms: ___improving ___getting worse ___about the same ___intermittent (comes & goes)
4. What activities aggravate your condition? ___standing ___walking ___sitting ___lying ___bending ___lifting ___twisting ___coughing other_____
5. Which best describes the quality of your complaint? ___sharp ___dull ___aching ___burning ___numbing ___pins & needles ___radiating other_____
6. Which best describes the character of your complaint: ___mild ___slight ___moderate ___severe
7. Please circle the level of pain: No Pain 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Unbearable Pain
8. How often are you aware of the complaint? ___0-25% ___26-50% ___51-75% ___76-100%
9. Have you ever had these symptoms before? ___yes ___no when?_____
10. What seems to help relieve the symptoms? ___medication ___over the counter medication ___rest ___heat ___ice ___stretching other_____
11. Have you seen another doctor for this condition? ___MD ___DC ___DO ___Lac other_____
    Name of practitioner:_____ Date:_____ Diagnosis:_____
    Results of treatment: ___good ___fair ___poor Type of treatment received:_____
    Any diagnostic tests performed? ___x-ray ___MRI ___CT ___PET ___lab other_____
    Results:_____

Please draw / shade in the location of your current pain / discomfort.

A = aching B = burning N = numbing P = pins & needles S = stabbing O = other



Past History

1. Please list any previous accidents or injuries: _____
   _____
2. Please list any surgeries or hospital stays and age when performed: _____
   _____
3. Do you have a family history of: ___cancer ___diabetes ___heart disease ___stroke ___arthritis
   Please list family member and condition: _____

Social History

1. Do you smoke tobacco? ___yes ___no How many years? _____ how much per day? _____
2. Do you drink alcohol? ___yes ___no how much per day, week, month? _____
3. Do you exercise? ___yes ___no what type? _____ how often? _____
4. Do you drink coffee/tea? ___yes ___no how much per day? _____

Allergies

1. Please list any and all allergies: _____
   _____

Medications

1. Please list all medications and supplements you are currently taking (prescription and over the counter): _____
   _____
   _____
   _____

Do you have a past or current history of any of the following?

Cardiovascular

1. ___High blood pressure
2. ___Stroke
3. ___Heart disease or murmur
4. ___Peripheral valve disease

Respiratory

5. ___Bronchitis
6. ___Pneumonia
7. ___Emphysema

Gastro-intestinal

8. ___Ulcers/stomach disorders
9. ___Intestinal disorders/IBS
10. ___Gall bladder disease
11. ___Liver disorders

_____

_____

_____

Endocrine

12. ___Thyroid
13. ___Diabetes
14. ___Adrenals

Genito-urinary male

15. ___Prostate
16. ___Urinary infection
17. ___Kidney
18. ___Genital/testicle

Genito-urinary female

19. ___Urinary infection
20. ___Vaginal/tubes
21. ___Abnormal bleeding
22. ___Kidney
23. ___Dysmenorhea/PMS

_____

_____

Musculo-skeletal

24. ___Arthritis
25. ___Fibromyalgia
26. ___Tendonitis/bursitis
27. ___Scoliosis
28. ___Extremity disorders
29. ___Muscle twitching

Other

30. ___Cancer/tumors
31. ___Neurologic disorder

_____

32. ___Psychiatric condition

_____

33. ___Auto immune disorder

_____

34. ___Pregnant

_____

Please check current complaints

General symptoms:

1. ___Nervousness
2. ___Irritability
3. ___Fatigue
4. ___Depression
5. ___Loss of sleep
6. ___Tension
7. ___PMS
8. ___Jaw pain

Headache:

1. ___Mild
2. ___Moderate
3. ___Severe
4. ___day / week / month

Location:

1. ___Back of head
2. ___Forehead
3. ___Temples
4. ___Right side
5. ___Left side
6. ___Behind eyes

Other:

1. ___Light headed
2. ___Memory loss
3. ___Fainting
4. ___Blurred vision
5. ___Double vision
6. ___Sensitive to light
7. ___Loss of balance
8. ___Hearing loss
9. ___Ringing in ears

Neck:

Pain:

1. ___Left side
2. ___Right side
3. ___Both

Pain level:

1. ___Mild___Mod. ___Severe

Pain increased by:

1. ___Forward movement
2. ___Backward movement
3. ___Left rotation
4. ___Right rotation
5. ___Left bending
6. ___Right bending

Other:

1. ___Stiffness
2. ___Muscle spasm
3. ___Grinding sound

Shoulders:

1. ___Pain in joint L R Both
2. ___Pain across shoulders L R Both
3. ___Limited movement L R Both
4. ___Tension L R B

Pain level:

1. ___Mild___Mod. ___Severe

Arms:

1. ___Pain in upper arm L R Both
2. ___Pain in elbow L R Both
3. ___Pain in forearm L R B
4. ___Arm Pins & needles L R Both
5. ___Forearm pins & needles L R Both
6. ___Numbness in arm L R Both
7. ___Numbness in forearm L R Both

Pain level:

1. ___Mild___Mod. ___Severe

Hands:

1. ___Pain in Wrist L R Both
2. ___Pain in hand L R Both
3. ___Pins & needles L R B
4. ___Numbness L R Both

Pain level:

1. ___Mild___Mod. ___Severe

Midback:

1. ___Pain L R Both

Pain level:

2. ___Mild___Mod. ___Severe
3. ___Muscle spasm R L Both

Chest:

1. ___Deep chest pain L R B

Pain level:

2. ___Mild ___Mod. ___Severe
3. ___Pain around ribs L R B
4. ___Shortness of breath
5. ___Irregular heartbeat

Abdominal symptoms:

1. ___Nervous stomach
2. ___Nausea
3. ___Gas
4. ___Constipation
5. ___Heartburn
6. ___Indigestion
7. ___Constipation
8. ___Diarrhea
9. ___Loss of appetite

Low back:

1. ___Upper lumbar pain L R Both
2. ___Lower lumbar pain L R Both
3. ___Sacroiliac pain L R B
4. ___Muscle spasm L R B

Pain level:

1. ___Mild ___Mod. ___Severe

Hips and legs:

1. ___Pain in buttocks L R B
2. ___Pain in hip joint L R B
3. ___Pain down leg L R B

Location: ___front ___back ___side

Pain radiates to: ___knee ___calf ___foot

4. ___Numbness down leg L R Both

Location: ___front ___back ___side

5. ___Pins & needles (Legs) L R Both

Location: ___front ___back ___side

6. ___Knee pain L R Both
7. ___Leg cramps L R Both

Feet:

1. ___Ankle pain L R Both
2. ___Swollen ankle L R B
3. ___Foot pain L R Both
4. ___Numb feet L R Both
5. ___Swollen feet L R Both
6. ___Cramps L R Both

Review of Systems:

Please check all that apply:

1. ___Abnormal weight gain
2. ___Abnormal weight loss
3. ___Fever of chills
4. ___Trouble sleeping
5. ___Fatigue
6. ___Weakness

Head

7. ___Headache / migraine
8. ___Head injury

Eyes

9. ___Blurred vision
10. ___Painful eyes
11. ___Redness of eyes
12. ___Double vision
13. ___Flashing lights
14. ___Specks
15. ___Glaucoma
16. ___Cataracts

Ears

17. ___Ear drainage
18. ___Ringing in the ears
19. ___hearing difficulty

Nose

20. ___Nasal discharge
21. ___Stuffiness
22. ___Itching nose
23. ___Hay fever
24. ___Nosebleeds
25. ___Sinus pain
26. ___Loss of ability to smell

Mouth

27. ___Bleeding gums
28. ___Dentures
29. ___Sore tongue
30. ___Dry mouth
31. ___Thrush
32. ___Loss of taste of food

Cardiovascular

33. ___Chest pain
34. ___Discomfort in chest
35. ___Tightness in the chest
36. ___Heart palpitations
37. ___Shortness of breath
38. ___Shortness of breath with activity
39. ___Shortness of breath without activity
40. ___Difficulty breathing
41. ___Difficulty breathing lying down
42. ___Swelling / edema
43. ___Wake suddenly with shortness of breath
44. ___Calf pain with walking
45. ___Leg cramping

Respiratory

46. ___Painful breathing
47. ___Cough dry, wet, productive
48. ___Sputum
49. ___Coughing up blood
50. ___Shortness of breath
51. ___Wheezing

Gastrointestinal

52. ___Swallowing difficulties
53. ___Heartburn

54. ___Change in appetite
55. ___Nausea
56. ___Change in bowel habits
57. ___Rectal bleeding
58. ___constipation
59. ___Diarrhea
60. ___Yellow eyes & skin
61. ___GERD symptoms

Genitourinary

62. ___Increase in urinary frequency
63. ___Urinary urgency
64. ___Burning or painful urination
65. ___Blood in the urine
66. ___Incontinence
67. ___Change in urinary strength
68. ___Pain with sex
69. ___Sores, masses, pain, itching or rash
70. ___STD's
71. ___Vaginal dryness
72. ___Vaginal discharge
73. ___Hot flashes
74. ___Penile discharge
75. ___Erectile dysfunction
76. ___Hernia

Integumentary

77. ___Rashes
78. ___Itching
79. ___Lumps
80. ___Dryness
81. ___Hair and nail changes
82. ___Breast feeding
83. ___Lumps in the breast
84. ___Painful breast
85. ___Discharge from breast
86. ___Performs self breast exam ___y ___n

Neurological

87. ___Dizziness
88. ___Fainting
89. ___Seizures
90. ___Weakness
91. ___Numbness
92. ___Tingling
93. ___Tremor

Psychiatric

94. ___Changes in attention
95. ___Changes in focus
96. ___Difficulty w/ long term memory
97. ___Difficultly w/ short term memory

Endocrine

98. ___Abnormally hot
99. ___Abnormally cold
1. ___Intolerance to heat
2. ___Intolerance to cold
3. ___Sweating Abnormally
4. ___Frequent urination
5. ___Excessive thirst
6. ___Excessive appetite
7. ___Unexplained weight gain
8. ___ Unexplained weight loss