Name: _____ **Today's date:** _____
(First) (Last) (Middle)

Birth date: _____ **Height:** _____ **Weight:** _____ **Sex:** _____

Please indicate where your pain and problem areas are located: _____

_____

Date you first noticed the pain/problem: _____

Please mark the boxes indicating any of the health problems you have experienced, *past or present:*

GENERAL
[ ] Allergies (list below)
[ ] Convulsion
[ ] Dizziness or fainting
[ ] Headache
[ ] Tingling sensation
[ ] Numbness

GASTROINTESTINAL
[ ] Colon trouble
[ ] Constipation
[ ] Diarrhea
[ ] Difficult digestion
[ ] Distention of abdomen
[ ] Liver problems
[ ] Gall Bladder trouble/stones
[ ] Pain in stomach/heartburn
[ ] Hemorrhoids

RESPIRATORY
[ ] Chest Pain
[ ] Chronic cough
[ ] Difficulty breathing
[ ] Spitting up blood
[ ] Coughing up phlegm
[ ] Wheezing

MUSCLE & JOINT
[ ] Arthritis
[ ] Bursitis
[ ] Foot pain/trouble
[ ] Low back pain
[ ] Neck pain or stiffness
[ ] Pain between shoulders
[ ] Sciatica/leg pain
[ ] Swollen joints
[ ] Shoulders
[ ] Arms
[ ] Elbows
[ ] Hands
[ ] Hips
[ ] Legs
[ ] Knees
[ ] Feet

EYES, EARS, NOSE & THROAT
[ ] Colds/Coughs
[ ] Deafness
[ ] Ear infections/aches
[ ] Ear discharge
[ ] Ringing/noise in ears
[ ] Eye pain
[ ] Nasal obstruction
[ ] Nosebleeds
[ ] Sinus infections

URINARY
[ ] Kidney stones
[ ] Incontinence
[ ] Frequent urination
[ ] Bed wetting
[ ] Blood in urine
[ ] Painful urination
[ ] Prostate trouble
[ ] Pus in urine
[ ] Kidney infections

CARDIOVASCULAR
[ ] Arteriosclerosis
[ ] High/low pressure
[ ] Chest/heart pain
[ ] Poor circulation
[ ] Irregular heartbeat
[ ] Swelling of ankles

SKIN
[ ] Bruise easily
[ ] Abrasions
[ ] Varicose veins
[ ] Dryness/rashes

DATE OF LAST EXAM
_____ Physical exam
_____ Blood test
_____ Urine test
_____ Spinal x-ray
_____ MRI/NCV/CT

HABITS
[ ] Alcohol
[ ] Caffeine
[ ] Tobacco
[ ] Drugs
[ ] Exercise

HAVE YOU EVER
[ ] Been knocked unconscious?
[ ] Used a crutch/cane or other support?
[ ] Had a fractured/broken bone?
[ ] Been hospitalized other than surgery?
[ ] Ever had any surgery?

PLEASE INDICATE IF: pain wakes you up, while you sleep [ ] and/or you experience night sweats [ ]

Please list any prescription now used, allergies or past surgeries: _____

_____

Check any conditions you **have or had**---circle items that are common to other <u>family</u> members

[ ] Alcoholism	[ ] Cancer	[ ] Emphysema	[ ] Polio	[ ] Tuberculosis
[ ] Anemia	[ ] Eczema	[ ] Gout	[ ] Rheumatic Fever	[ ] Ulcer
[ ] Appendicitis	[ ] Goiter	[ ] Heart disease	[ ] Stroke	[ ] Foot problem
[ ] Anxiety	[ ] Hepatitis	[ ] Miscarriage	[ ] Multiple Sclerosis	[ ] Diabetes

Please sign, your signature verifies that all information given is accurate to the best of your knowledge.

Signature: _____ Date: _____