

PATIENT HISTORY

Date of Birth _____ Age _____ Social Security # _____
 Last _____ First _____ Middle Initial _____
 Address _____ City _____ ST _____ Zip _____
 Phone (H) _____ (W) _____ (C) _____
 Email _____ May we send you our online newsletter? yes no
 Your Occupation _____ Employer _____
 Spouse/Partner Name _____ Spouse/Partner DOB _____
 Have you been to another doctor for this problem? yes no Who/Where? _____
 Who may we thank for referring you to this office? _____

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____
 Date when symptom first appeared _____ Did it begin: Gradual Sudden Progressive over time
 What makes the symptoms increase? _____ What relieves the symptoms? _____
 Type of Pain: Sharp Dull Ache Burn Throb Does the Pain Radiate into your: Arm Leg Does not radiate
 Do you have Numbness or Tingling? yes no How often do you experience these symptoms? 100% 75% 50% 25% 10%
 Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____
 Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

 Do you have any family members who suffer from the same complaint? If so, who? _____

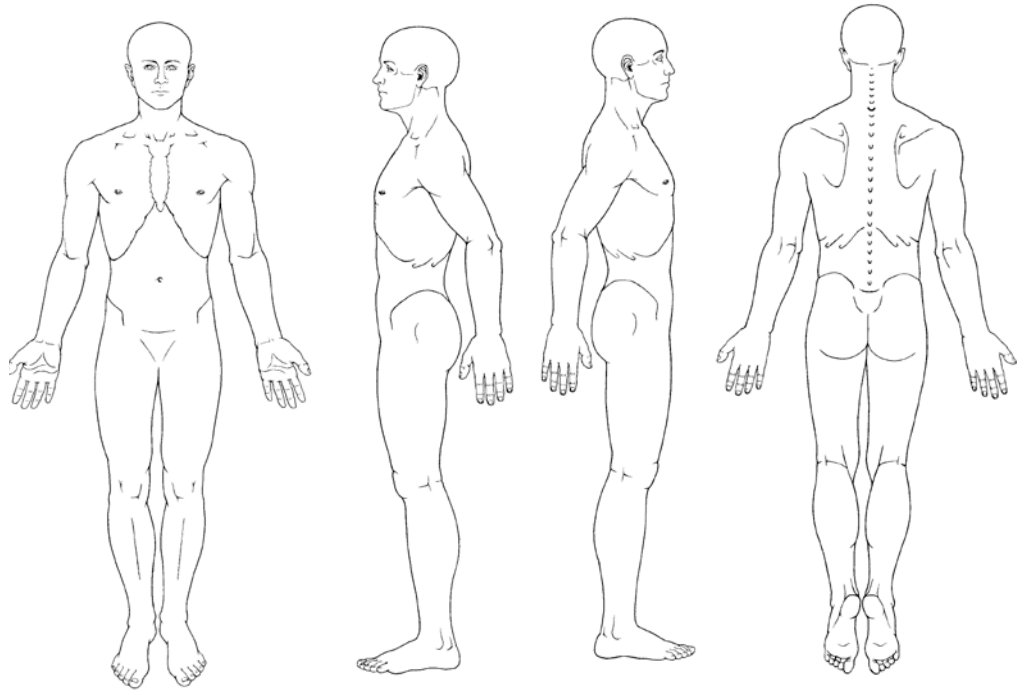
SECONDARY COMPLAINT: _____
 Date when symptom first appeared _____ Did it begin: Gradual Sudden Progressive over time
 What makes the symptoms increase? _____ What relieves the symptoms? _____
 Type of Pain: Sharp Dull Ache Burn Throb Does the Pain Radiate into your: Arm Leg Does not radiate
 Do you have Numbness or Tingling? yes no How often do you experience these symptoms? 100% 75% 50% 25% 10%
 Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____
 Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

Do you smoke? yes no If yes, how many packs per week? _____
 Have you ever smoked in the past? yes no If yes, when did you quit? _____
 Do you take birth control? yes no Have you ever taken birth control in the past? yes no
 Do you consume alcohol? yes no If yes, how many drinks per week? _____
 Do you consume caffeine? yes no If yes, how many drinks per day? _____
 Do you exercise? yes no If yes, how many times per week and what type? _____
 Do you have a high stress level? yes no If yes, list reasons: _____

Please list any medications or vitamins you are currently taking:

PATIENT SIGNATURE _____ DATE _____

Please mark off the areas of your complaint on the diagram above with the following indicators:
 PPP = pain
 NNN = numbness
 TTT= tingling
 BBB= burning
 CCC= cramping
 XXX = other



Please list all surgeries, injuries, accidents, falls, etc: _____

Please check if you have had any of the following:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anemia	<input type="checkbox"/> Allergy Shots	<input type="checkbox"/> Anorexia
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Disc Degeneration	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Gout
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Herpes
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Measles
<input type="checkbox"/> Migraine	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> MS	<input type="checkbox"/> Mumps
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Stroke
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tumors/Growths	<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Vascular Disease
<input type="checkbox"/> Vaginal Infections	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Other:				

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