Welcome

Date: ___/___/___

Name: ____________________ Date of Birth: ___/___/___ Age: __________
Address: ____________________ City: __________ State: ______ Zip: ______
E-Mail: ______________ Home #: ______________ Work/Cell #: __________
SS#: ____________ Marital Status: ____________ # of children: ____ Age(s): ________
Occupation: ____________ How did you hear about us? ______________

Present Complaint

Present complaint: ______________________________

Pain or problem started on ___/___/___ How? ______________________

Pain is □ sharp □ dull □ aching □ shooting □ burning
□ throbbing □ deep □ nagging □ constant □ intermittent
□ other: ______________________________

Intensity/severity: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst possible)

Does this complaint radiate or travel to any other area of your body? If yes, where?

____

What activities aggravate your condition/pain? ______________________

Is this condition interfering with work? __________ Sleep? ______ Routine? __________

Is this condition getting progressively worse? ______________________

Other doctors seen for this condition? ______________________

What activities relieve your condition/pain? ______________________

Any home remedies? ______________________

Other Symptoms (present or past)

□ headaches □ fainting □ loss of smell □ loss of taste □ loss of balance
□ dizziness □ cold sweats □ loss of memory □ ringing in ears □ light sensitivity
□ face flushed □ neck pain □ stiff neck □ cold hands □ grinding teeth
□ pins & needles in arms □ numbness in fingers □ arm/elbow/hand pain

□ back problems □ pins & needles in legs □ knee/leg/foot pain
□ numbness in toes □ cold feet

□ irritability □ depression □ nervousness □ chest pain □ tension □ fatigue
□ shortness of breath □ sleeping problems
□ constipation □ diarrhea □ stomach upset

□ bowel □ bladder □ heart □ lung □ thyroid □ liver
□ gallbladder □ endocrine □ vision □ fever

□ other: ______________________________