

SOCIAL HISTORY

Married _____ Divorced _____ Widowed _____ Single _____
What is your occupation? _____ Retired / Disabled _____

Do you smoke? _____ How many per day? _____
How many years? _____

Do you drink? _____ Beer _____ Wine _____ Alcohol _____
How many drinks per day? _____

Do you drink coffee? _____ Cups per day? _____
Have you ever used street drugs, cocaine, marijuana, etc.? _____
(If yes, describe) _____

In the past have you taken perscription narcotics? _____
(If yes, describe why and for how long) _____

FAMILY HISTORY: (please indicate if any relative has, or had)

_____ Hypertension _____
_____ Diabetes _____
_____ Thyroid _____
_____ Heart Attack _____
_____ Stroke _____
_____ Breast Cancer _____
_____ Colon Cancer _____
_____ Ovarian Cancer _____

Any other history of cancer: _____

SYSTEMS REVIEW Please circle if you have or have had any of the following:

General

Recent Weight Change
Fever/Chills
Fatigue
Night Sweats

Skin and Hair

Rashes/Sores
Skin cancers or melanomas
Hair loss
Unusual lumps under skin

Endocrine

Diabetes
Thyroid Disease
High Blood Pressure
Other

Ear, Nose & Throat

Glasses/contacts/laser surgery eye
Double vision
Hearing loss
Persistent ringing in ears
Difficulty swallowing
Pain or stiffness in the neck
Fullness in the neck or throat
Hoarseness or voice change

Lungs

Shortness of breath
Emphysema or chronic bronchitis
Asthma or wheezing
Congestive heart failure
Persistent cough
Pneumonia

Heart and Blood Vessels

Heart attacks
Chest pain
Heart murmur
Heart surgery
Irregular heart beat (palpitations)
Swelling in feet
Phlebitis or blood clots
High Blood pressure

Gastrointestinal

Difficulty swallowing
Heartburn
Hernias
Ulcer disease
Jaundice
Hepatitis or other liver disorders
Colitis
Irritable bowel syndrome
Crohns' disease
Constipation
Diarrhea
Hemorrhoids/rectal disorders
Blood in stool
Abdominal pain
Esophageal stricture
Diverticular disease/diverticulitis

Musculoskeletal

Arthritis - Osteoarthritis/Rheumatoid
Joint pain, stiffness or swelling
Decreased muscle strength
Previous bone disease
Any broken bones
Back pain/back surgery
Neck pain/neck surgery

Neurological

Headaches
Dizziness/fainting
Weakness or tingling of arms or legs
History of any head injury

Blood

Anemia
Blood transfusions
If yes, when, how much and why _____

Infections

Any serious infection _____
Childhood illnesses:
 measles, mumps, chicken pox
Last tetanus shot _____
Last flu shot _____

For women only

Abnormal bleeding or discharge
Any gynecological surgery
Kidney stones
Urinary tract infections
Sexually transmitted diseases
(gonorrhea, syphilis, herpes, venereal warts, AIDS, etc.)
Age of first menstrual period _____
Number of pregnancies _____
Number of live births _____

Breasts

Breast pain
Nipple discharge
Breast lumps
Previous breast surgery

For men only

Kidney stones
Prostate disease
Difficulty urinating
Urinary tract infections
Vasectomy
Sexually transmitted diseases:
 gonorrhea syphilis herpes
 venereal warts AIDS, etc.

If you circled any of the above explain in detail below under additional information.

Additional Information

Date of injury/Onset of Symptoms: _____ Is this a work related injury? _____ Date Stopped Work (if applicable): _____

If work related, name of employer or place of business when injured: _____

What area of the body is involved? Symptoms? _____

If this is an injury, how did it happen? _____

What treatment have you had? Chiropractic? Physical Therapy? Acupuncture? Traction? "Alternative Therapies?" _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Have you had problems with past anesthesia? _____ If yes, please explain: _____

Have you ever taken steroids? _____ When? _____ For how long? _____

Why? _____

Patient Signature _____ Date _____

Thank you for providing complete information.

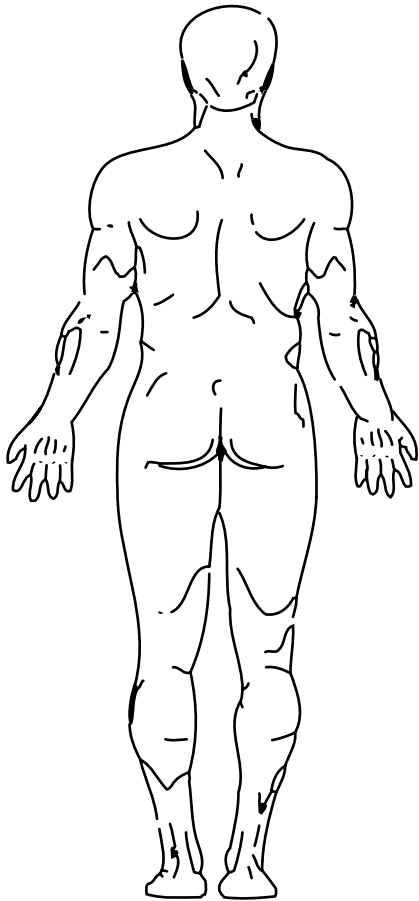
Physician Signature _____ Date _____

PAIN DIAGRAM

Name: _____ Date: _____

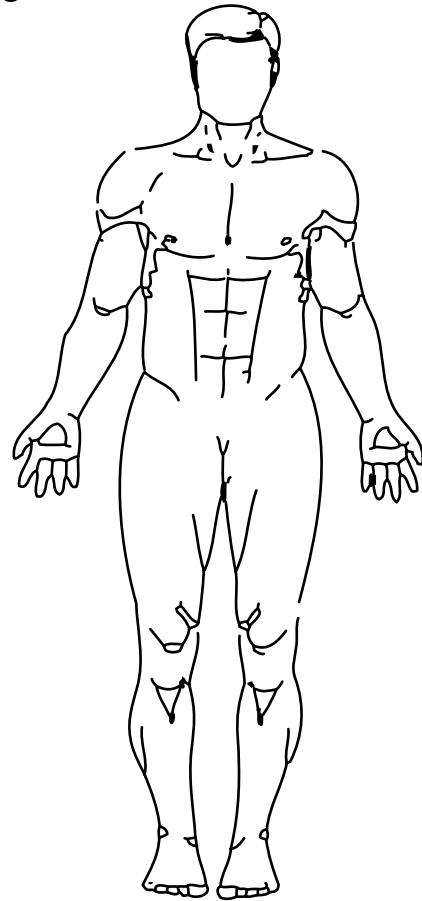
Left

Right



Right

Left



PLEASE CIRCLE THE NUMBER REPRESENTING YOUR OVERALL PAIN INTENSITY

0 1 2 3 4 5 6 7 8 9 10
(no pain) (severe)