Patient Name:____ DOB:______________________________

Married________ Single_______________ # of children living with you________________

Occupation____

What is the main problem you are seeking treatment for today? _____________________________________

How did the pain start/ injury occur?___________________________ Date:___________________________

Does pain wake you at night?_________ Was your pain different when it started? If yes, how?_________________________________

In the past month, have you thought you are getting: _____Better ______ Worse ______Same

On a scale of zero to ten (no pain to pain requiring hospitalization), please rate your pain today:____________

Have you researched your problem through the internet?______ Yes ______No

Family Physician______________________ Referring Doctor________________________

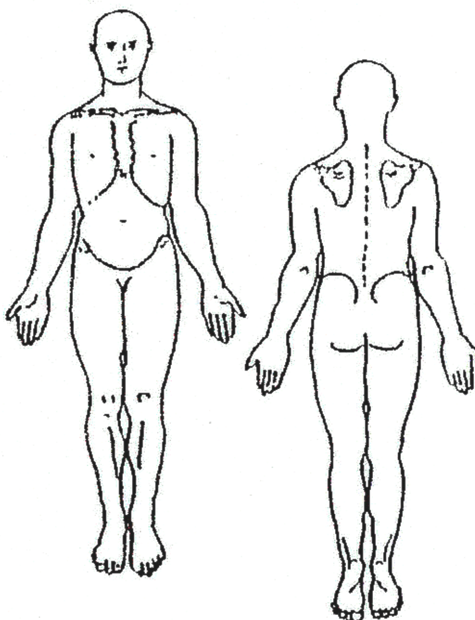
Are you or could you be pregnant? _______ Do you have ALLERGIES? ________ If yes, to what::____________________

Have you seen a medical provider of any kind in the last three months? ____

Have you EVER been diagnosed with any of the following?

Condition			If YES Dates
Cancer	yes	no	________
If yes, what kind?___________			
How treated?___________			________
Heart Attack	yes	no	________
Pacemaker	yes	no	________
High Blood Pressure	yes	no	________
Asthma	yes	no	________
Emphysema	yes	no	________
Chemical Dependency	yes	no	________
Thyroid Problems	yes	no	________
Diabetes	yes	no	________
Multiple Sclerosis	yes	no	________
Rheumatoid Arthritis	yes	no	________
Other types of Arthritis	yes	no	________
Depression	yes	no	________
Hepatitis	yes	no	________
Tuberculosis	yes	no	________
Stroke	yes	no	________
Kidney Disease	yes	no	________
Anemia	yes	no	________
Epilepsy	yes	no	________
AIDS/HIV	yes	no	________
Long Term Steroid Use	yes	no	________
Recent Respiratory Infection	yes	no	

Indicate your symptoms on the body:
X= pain O= numbness/tingling



Do not fill in.
For Medical Professional Use:

BP_______________

Wt_______________

HR_______________

RR_______________

Notes:__________________________
____
____
____
____
____
____
____

Do you drink caffeine?_______________ Alcohol? ______________ Tobacco products?____________ Recreational Drugs?_____________

Please list all PRESCRIPTION Medications you are currently taking:____
____

Non-Prescription/Herbal?____

Please list any surgeries, injuries, or conditions for which you have been hospitalized or treated:

Date	Surgery/Hospitalization/Injury
______	____
______	____
______	____

Patient Signature____ Date ______________________________