

(Please Print)

PATIENT INFORMATION

Today's date:		Primary Care Physician:			
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss.	Marital status (check one)
				<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Significant Other
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Social Security No.:		Home phone no.: ()	
				Cell phone no.: ()	
P.O. Box:	City:	State:		ZIP Code:	
Occupation:		Employer:		Employer phone no.: ()	
Chose clinic because / Referred to clinic by (please check one box):					
<input type="checkbox"/> Dr. Referral <input type="checkbox"/> newspaper <input type="checkbox"/> Hospital <input type="checkbox"/> Family/Friend <input type="checkbox"/> TV <input type="checkbox"/> Dinner Event <input type="checkbox"/> Mailer <input type="checkbox"/> Other					
Email:			Spouse's Name:		
Please List any other family members/friends involved in your health decisions:					
Insurance Name:			<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Other _____		
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address)		Relationship to patient:	Home phone no. : ()	Work phone no. : ()	
The above information is true to the best of my knowledge.					
Patient/Guardian signature:			Date:		

Patient Name: _____ Today's Date: _____

What is your major complaint?

How long have you had this problem?

Before you began having this problem was there an earlier condition, accident, or injury that could have brought this problem about? Yes No If so please describe:

What have you tried for treatment that did not work?

Have you seen a M.D., P.T., or a D.C. for this problem?

Yes No

Doctor's Name	Specialty	Year(s) Seen

How does this problem interfere with your daily day life?

Have you been worried about getting this problem resolved?

Yes No If yes, please describe:

What is your main concern about your symptoms?

On a scale from 1 to 10 (with 10 being the highest), what is your interest in getting help for the problem?

	0	1	2	3	4	5	6	7	8	9	10
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***PLEASE BRING A LIST OF YOUR MEDICATIONS TO REVIEW WITH THE DOCTOR
OR WRITE IT ON THE BACK OF THIS SHEET**

Patient Name: _____

Today's Date: _____

Personal History

Check all conditions that apply to you:

<p>General</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fatigue, tiredness <input type="checkbox"/> Weakness <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Night sweat <input type="checkbox"/> Appetite change <input type="checkbox"/> Lived in foreign country <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Unexplained weight gain <input type="checkbox"/> Generalized pain <input type="checkbox"/> Unable to tolerate heat <input type="checkbox"/> Unable to tolerate cold <input type="checkbox"/> Sedentary lifestyle <input type="checkbox"/> Active lifestyle <input type="checkbox"/> Other _____ 	<p>Neurological</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fainting spells <input type="checkbox"/> Seizures <input type="checkbox"/> Paralysis <input type="checkbox"/> Dizziness <input type="checkbox"/> Tremor <input type="checkbox"/> Chronic headaches <input type="checkbox"/> Poor balance <input type="checkbox"/> Fractured back or neck <input type="checkbox"/> Numbness of face / arm / leg <input type="checkbox"/> Peripheral neuropathy <input type="checkbox"/> Stroke or Mini – stroke <input type="checkbox"/> Other _____ 	<p>Psychiatric</p> <ul style="list-style-type: none"> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety (abnormal) <input type="checkbox"/> Panic attacks <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Confusion (abnormal) <input type="checkbox"/> Hospitalized for nervousness <input type="checkbox"/> Substance abuse <input type="checkbox"/> Anorexia <input type="checkbox"/> Other _____ 	<p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chronic obstructive disease <input type="checkbox"/> Wheezing <input type="checkbox"/> Chronic cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Asthma <input type="checkbox"/> Shortness of breath <input type="checkbox"/> TB <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Fluid in lungs <input type="checkbox"/> Need to sleep sitting up <input type="checkbox"/> Other _____
<p>Cardiac</p> <ul style="list-style-type: none"> <input type="checkbox"/> Angina (chest pain) <input type="checkbox"/> Rapid heartbeat <input type="checkbox"/> Past heart attacks <input type="checkbox"/> Heart murmur <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> High blood pressure <input type="checkbox"/> Aortic aneurysm <input type="checkbox"/> Other heart problem <input type="checkbox"/> Pacemaker <input type="checkbox"/> Defibrillator <input type="checkbox"/> Other _____ 	<p>Vascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> Leg pain walking over 1 block <input type="checkbox"/> Leg pain walking less than 1 block <input type="checkbox"/> Pain in legs while at rest <input type="checkbox"/> Blood clots in legs <ul style="list-style-type: none"> <input type="checkbox"/> Deep <input type="checkbox"/> Superficial <input type="checkbox"/> Cold feet or hands <input type="checkbox"/> Amputation of toes <input type="checkbox"/> Amputation of feet or legs <input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/> Ulcers of lower legs <input type="checkbox"/> Varicose veins <input type="checkbox"/> Aneurysm of arteries <input type="checkbox"/> Other _____ 	<p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Stool changes <input type="checkbox"/> Bowel habits changes <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Ulcers <input type="checkbox"/> Irritable bowel <input type="checkbox"/> Colon polyps <input type="checkbox"/> Cramps/ pains <input type="checkbox"/> Cancer of the stomach or bowel <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Other _____ 	<p>Genitourinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hesitancy / urgency of urine <input type="checkbox"/> Need to urinate often at night <input type="checkbox"/> Loss of bladder control <input type="checkbox"/> Difficult urination <input type="checkbox"/> Renal failure <input type="checkbox"/> Impotence <input type="checkbox"/> Current Dialysis <input type="checkbox"/> Renal transplant <input type="checkbox"/> Prostate enlargement <input type="checkbox"/> Cancer of bladder/ kidneys <input type="checkbox"/> Other _____
<p>Blood & Lymph System</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Blood disease <input type="checkbox"/> Transfusions <input type="checkbox"/> Leukemia <input type="checkbox"/> Bone marrow test <input type="checkbox"/> Long term Coumadin use <input type="checkbox"/> Blood clotting problems <input type="checkbox"/> Other _____ 	<p>Eyes, Ears, Nose & Throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Polyps <input type="checkbox"/> Vertigo <input type="checkbox"/> Ringing in ears (tinnitus) <input type="checkbox"/> Sinus infections <input type="checkbox"/> Deafness <input type="checkbox"/> Other _____ 	<p>Musculoskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint swelling <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Muscle aches <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Leg cramps <input type="checkbox"/> Other _____ 	<p>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rashes <input type="checkbox"/> Tumors <input type="checkbox"/> Sensitivity to sunlight <input type="checkbox"/> Malignant melanoma <input type="checkbox"/> Squamous cell carcinoma <input type="checkbox"/> Basal cell carcinoma <input type="checkbox"/> Easy bruising <input type="checkbox"/> Fungal infections <input type="checkbox"/> Non-healing sores <input type="checkbox"/> Excessive rough or dry skin <input type="checkbox"/> Other _____
<p>Endocrine</p> <ul style="list-style-type: none"> <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Diabetes – Type 1 <input type="checkbox"/> Diabetes – Type 2 	<p>Abnormal Organs</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hepatitis <input type="checkbox"/> Cirrhosis (Liver) <input type="checkbox"/> Gallbladder disease 	<p>Height: _____</p> <p>Weight: _____</p>	