

Date of Visit: _____ OC # _____
 Patient Full Name: _____ Age: _____ DOB: _____
 Who referred you to our office? _____ Height: _____ Weight: _____

Reason for Visit

Please describe the reason for today's visit: _____

When did your current symptoms begin or injury occur? _____

Are your current symptoms related to an injury? No Yes Please describe; _____

If your current symptoms are related to an injury do you have a lawyer? No Yes

Have you had this problem before? No Yes Please describe; _____

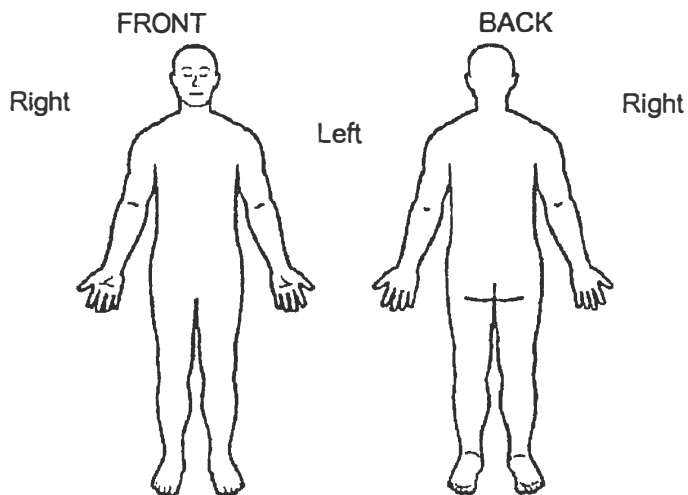
How would you describe your pain now?

- Constant
- Intermittent
- Burning
- Sharp
- Stinging
- Dull
- Throbbing
- Aching

Pain is:

- Equal on both sides
- Only or worse on the right side
- Only or worse on the left side

Mark areas below where you are having pain with an X, and numbness/tingling with an O.



Please rate your pain now.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Ever

Please rate your pain at its worst.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Ever

What makes your pain worse?

- All Activity
- Sitting
- Standing
- Walking
- The pain wakes you from sleep
- Other _____
- Lifting
- Bending
- Twisting
- Nothing
- Coughing
- Sneezing
- Lying Down

What makes your pain better?

- Nothing
- Lying Down
- Ice
- Heat
- Other _____
- Activity
- Exercise
- Sitting
- Standing
- Walking
- Twisting
- Bending forward
- Bending backward

Have you had:

- Inability to urinate
- Arm or leg weakness
- Loss of balance while walking
- Falls

Are your symptoms getting:

- Better
- Worse
- Staying the Same

What is your current work status?

- Out of Work
- Light Duties
- Full Duties
- Retired

List anything else you can not do or have had to change because of your symptoms. _____

Who else have you seen for this problem?

What tests have you had for this problem?

- X-rays
- MRI
- Blood Work
- CT Scan
- Myelogram
- EMG or Nerve Conduction

Have you tried any of the following?

- Chiropractor
- Accupuncture
- Physical Therapy
- Massage Therapy

What medications have you tried? Circle which work best.

Have you received any injections?

- No Yes What kind? _____

For Office Use Only: Blood Pressure ____/____ Pulse _____ Temperature _____

Date of Visit: _____ **OC#:** _____
Patient Full Name: _____ **Date of Birth:** _____ **Age:** _____
Who is your Primary Care Provider? _____ **Pharmacy Name:** _____
What was your sex at birth? Male Female Other _____ **Pharmacy Phone#:** _____
In an effort to accurately refer to you in our office, please let us know which gender you identify with:
 Male Female Other _____ Decline

Medical Conditions

None OR Write "P" for Past and "C" for Current Problem (Use other* if problem not listed.)

<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Anemia	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Blood Clots/DVT/Pulmonary Embolism	<input type="checkbox"/> Hepatitis/Disease	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Cancer: type _____	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Sickle Cell Trait/Disease
<input type="checkbox"/> COPD	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Stroke
<input type="checkbox"/> Dementia	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Depression	<input type="checkbox"/> MRSA	<input type="checkbox"/> Other: _____

Are you currently pregnant? N Y Are you currently breastfeeding? N Y
 Have you had a Pneumonia vaccine? N Y (if yes, date _____)
 Have you had a Flu shot in the last year? N Y (if yes, date _____)
 Have you had any falls in the last year? N Y If yes, how many? _____ Were you injured? _____
List Drug Allergies and Reaction: None

List Current Medications (including dosage and frequency): None See Attached List

List Any Past Surgeries and Date: None See Attached List

Family History

None Unknown/Adopted **OR** Indicate if any of your blood relatives (mother, father, sister, brother, daughter, son or grandparent) have had any of the following conditions. Please write beside condition the relative(s), as it applies.

<input type="checkbox"/> Bleeding Disorder _____	<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Osteoporosis _____
<input type="checkbox"/> Blood Disease _____	<input type="checkbox"/> Kidney Disease _____	<input type="checkbox"/> Respiratory _____
<input type="checkbox"/> Depression _____	<input type="checkbox"/> Muscle Disorders _____	<input type="checkbox"/> Rheumatoid Arthritis _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Nerve Disorders _____	<input type="checkbox"/> Cancer: _____
<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Osteoarthritis _____	type: _____
<input type="checkbox"/> Other: _____		

Social History

Tobacco Use: Never a Smoker Former Smoker _____ Year Quit Current Smoker _____ # Packs/Day _____ # Years
Alcohol Use: Never Rarely Weekly Daily **Occupation:** _____
Marital Status: Single Married Separated Divorced Widowed Other

Review of Systems

Indicate if you have current problems with any of the following: None

<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Bleeds Easily	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Psychological Disorder
<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Recent Weight Gain _____ lbs
<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Headaches	<input type="checkbox"/> Recent Weight Loss _____ lbs
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Recurring Fever
<input type="checkbox"/> Chest Pain / Discomfort	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Skin Problems
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Sleep Disturbances
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Increased Need to Urinate	<input type="checkbox"/> Temperature Intolerance
<input type="checkbox"/> Decreased Appetite	<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting

Patient Signature: _____ **For Office Use Only:** Date Reviewed _____ Change? Y or N _____ Clinical Staff _____ Provider _____