

# Symptoms *(Rate the level of your pain for each symptom: 1 mild – 10 severe)*

List symptoms: (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

When did you first notice your symptoms: \_\_\_\_\_

Is your pain: Decreasing No change Increasing

Is the pain constant or does it come and go: \_\_\_\_\_

Type of pain Sharp Dull Throbbing Aching Shooting Numb  
Tingling Burning Stiffness

Which activities are difficult to do: Sitting Standing Walking Bending Lying

What treatment have you already received for your condition: MD Physical Therapy Chiropractor

Name and address who have treated you: \_\_\_\_\_

Are you taking any medication for the pain: \_\_\_\_\_

## Health History

*Check only those conditions which are applicable:*

- |   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc      | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Depression          | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tumors, Growths    |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Polio                | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Measles             | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Miscarriage         | <input type="checkbox"/> Rheumatic Fever      | _____                                       |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gout                | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Scarlet Fever        | _____                                       |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Stroke               | _____                                       |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Suicide Attempt      | _____                                       |
| <input type="checkbox"/> Cataracts          | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Thyroid Problems     | _____                                       |

Dates of last exams: \_\_\_\_\_

(Women) are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

List any types of surgeries which you have had and the dates which the occurred: \_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_

Allergies: \_\_\_\_\_

## Daily Habits

What type of exercise do you perform on a daily basis? None Moderate Heavy

What do your daily work habits include (ex. sitting, standing, light labor, heavy labor, computer work) \_\_\_\_\_

What vitamins do you currently take? \_\_\_\_\_

What kind of other nutritional supplements do you take (if any)? \_\_\_\_\_

Do you smoke? No Yes How much per day? \_\_\_\_\_

How much liquor do you consume on a weekly basis? \_\_\_\_\_

How much coffee or caffeinated beverages do you consume on a daily basis? \_\_\_\_\_

X

SIGNATURE OF PATIENT (or parent if a minor)

DATE