Please print, and check the appropriate items

Skim through entire form before starting to fill this out.

Long answers may be continued on a separate sheet of paper.

CURRENT MEDICAL HISTORY

Patient name _____

Date of birth _____ Age _____ Today's Date _____

Who referred you? _____

Family Physician _____ Doctor's Phone _____

Address of family physician _____

_____

What are your Major Concern(s) _____

_____

_____

_____

_____

_____

What are your Other Concerns and when did they start _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

When did your major concern(s) begin (be specific) _____

_____

Pain and Problem History:

What seemed to really start it? If it was an injury, how did it happen? _____

_____

_____

_____

IF
you were involved in any auto accident(s), please include details about, seat belt, shoulder strap, air bag, position in the car, make and year of what hit you, how the accident(s) happened, treatment right afterwards, symptoms or change in symptoms after the injury, etc.

Have you had this diagnosed? (year) _____ What was the diagnosis? _____

Name of physician who diagnosed it: _____

Specialty of physician: _____

Address or general location of physician: _____

What kinds of treatment have you tried? When? And what were the results of each? _____

Include physical therapy, Chiropractor, Massage, Doctors, Clinics, Acupuncture?

Please make sure you help me understand how your condition developed over time… from when it started, until now:

If you have separate treatment histories for other conditions, please summarize them on a separate sheet of paper.

What home remedies have you tried for these conditions?

What do you do that makes it better or improves your symptoms?

What do you do that makes it feel worse?

List the weather conditions you feel best in: _____

List the weather conditions you feel worst in: _____

DIAGNOSTIC TESTING—Please bring a paper copy of test reports, and the actual films of plain x-rays if possible.

Don't copy the test report into this table.

Lab tests, Blood tests, MRI scan reports, CT scan reports, EMG reports etc.

TEST NAME	DATE TEST was DONE	FACILITY where test was DONE	WHAT RESULTS WERE YOU TOLD?

What SURGERIES have you had?

SURGERY	DATE	REASON for SURGERY	SUCCESSFUL?

Continue on separate sheet of paper if needed.

REVIEW OF SYSTEMS

Please check any symptoms that are bothersome to you NOW.

General

___Poor appetite	___Bleed/bruise easily	___Poor balance	___Change in appetite	___Fevers
___Poor sleeping	___Weight loss	___Weight gain	___Sweat easily	___Chills
___Fatigue	___Strong thirst	___Localized weakness	___Tremors	___Night sweats
___**Cravings for:**	___Sweets	___Fats	___Salty food	___Other_____

Skin & Hair

___Rashes	___Loss of hair	___Pimples	___Dandruff	___Recent moles	___Excema	___Hives
___Ulcerations	___Itching	___Change in hair	___Change in skin	___Herpes	___ Finger nails chip/crack/peel	___ Other

Cardiovascular

___High blood pressure	___Varicose veins	___Chest pains	___Irregular heartbeat
___Low blood pressure	___Fainting	___Cold hands	___Cold feet
___Phlebitis	___Swelling feet	___Swelling hands	___Blood clots
___Difficulty breathing	Other _____		

Head, Eyes Ears Nose & Throat

___Concussions	___Jaw clicks (TMJ) L or R	___Tooth problems	___# of teeth pulled
____# of silver fillings	___# Root canals	___Eye pain	___Poor vision
___Migraine	___Other headache	Type of headache _____	___Sores on lips/tongue
___Sinus problems	___Nose bleeds	___Spots in front of eyes	___Trouble with night vision
___Grinding teeth	___Facial pain	___Trouble with taste or smell	___Glasses
___Ear aches	___Cataracts	Other_____	

Immunology

Rheumatoid disease? ___Y ___N	Tested for Lyme disease? ___Y ___N	Diabetes? ___Y ___N	Thyroid problems? ___Y ___N
Cancer? ___Y ___N What Kind _____	Hepatitis? ___Y ___N What Kind_____	AIDS? ___Y ___N	Breast implants? ___Y ___N What Kind_____
Other communicable disease? _____			

Respiratory

___Cough	___Shortness of breath with minimal exercise	___Difficulty breathing when lying down	___Pain with deep breath
___Coughing blood	___Pneumonia	___Asthma	___Shortness of breath
___Bronchitis	Other _____		

Gastrointestinal

___Nausea	___Abdominal pain/cramps	___Indigestion	___Hemorrhoids	___Constipation
___Vomiting	___Diarrhea	___Black stools	___Belching	___Gas
___Rectal pain	___Blood in stools	___Bad breath	___Heartburn	___Pancreatitis
How many bowel movements a day_____	How many bowel movements a week ____	Other _____		

Genitourinary

___Pain with urination	___Frequent urination	___Blood in urine	___Urgency to urinate
___Unable to hold urine	___Kidney stone #:___	___Decrease in flow	___ Wake up to urinate
___Problem with sexual function	___Impotency	___Loss of libido (desire)	___ Pain with intercourse
___Sexually transmitted disease or exposure	___Sores on genitals	Other:	

Pregnancy & Gynecology

Pregnant? ___Y ___N	Planning a pregnancy? ___Y ___N	Post menopausal? ___Y ___N	Menopause symptoms? ___Y ___N
First date of last menses: _____	Unusual character (heavy/light) _____	Hot flashes? ___Y ___N	Fibrocystic breast ___Y ___N
___Clots	___Painful periods	___Irregular periods	___Vaginal discharge
___Vaginal sores	___Breast lumps	Birth control ___Y ___N	Type of birth control :
# of children: _____	# of C-section delivery(s)___	# of vaginal delivery(s) ___	# of abortion(s) _____
Ages of children _____	_____		

Musculoskeletal

__ Muscle pain	__ Muscle weakness	__ Jaw pain	__ Face pain	__ Neck pain
__ Shoulder pain	__ Elbow pain	__ Arm pain	__ Wrist pain	__ Hand pain
__ Finger pain	__ Upper back pain	__ Lower back pain	__ Hip pain	__ Thigh pain
__ Knee pain	__ Leg pain	__ Ankle pain	__ Foot pain	__ Toe pain
__ Osteoporosis	__ Scoliosis	__ Chest pain	__ Other:_____	_____

Neuropsychological

___Seizures	___Dizziness	___Loss of balance	___Lack of coordination
___Poor memory	___Concussion	___Depression	___Anxiety
___Bad temper	___Easily susceptible to stress	___Treated for emotional problems	___Aneurysm
Ever considered suicide? ___Y ___N	Ever attempted suicide? ___Y ___N	Areas of numbness? ___Y ___N	Where?
Other _____			

Other information you think is important that did not come up during review of systems:

Place check mark in box

Family History

	Father	Mother	Father's parents	Mother's parents	Siblings	Children
Heart disease						
High Blood pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/seizures						
Bleeding disorder						
Kidney disease						
Thyroid disease						
Mental illness						
Osteoporosis						
Fibromyalgia						
Other						

Additional History

Childhood illnesses: _____

Childhood accidents and any lasting effects: _____

_____

_____

_____

_____

_____

Current Medications

Current medications	Who prescribed them	What are they for	Are they helpful

Pharmacy

Current pharmacy: _____

Address or location: _____

Phone: _____

Allergies to medication and environment:

Medication allergies—list medicine and reaction:

Environmental allergies—list agent and reaction:

History of allergy testing and treatment:

Have you ever smoked Tobacco? Y N How many packs per day? _____ Now ?_____

How many years a smoker? _____ How many times did you quit? _____When?_____

Do you have a history of alcohol or drug abuse? Treatment for abuse? Please explain:_____

_____

_____

_____

_____

_____

Diet:

red meat — number of meals per week _____

milk — number of glasses per week _____ or per day _____

cheese — number of times per week _____ or per day _____

coffee or tea — number of cups per week _____ or per day _____.

soda — number of cans per week _____ or per day _____,

what kind usually? _____

other sugar — what sweets do you usually eat and how much? _____

_____

bread — what kind and how much? _____

which do you use margarine or butter? _____

what cooking oils do you use?_____

what are your favorite foods?_____

_____

_____

Vitamins: what do you take, and why (only list why for unusual supplements or herbs)?

_____

_____

_____

_____

Sleep: how well do you sleep? _____

If not well, why not? _____

_____

_____

What position do you sleep in? _____

_____

Do you use a pillow? what kind? where placed? _____

_____

_____

Do you have stomach sensitivity to aspirin? _____Y ____N

Do you have irritable bowel? _____ for how long? _____

How is this treated? _____

_____

Who is the treating doctor? _____

Do you have a history of ulcer or indigestion? _____ Y ____ N please explain: _____

_____

_____

_____

How is this treated and who is the doctor? _____

_____

_____

When was your last complete physical examination? _____

For what reason?_____

_____

What is your occupation? _____What was your occupation?_____

If you are disabled, when did you last work? _____

What is your disability caused by? _____

Anything else you would like us to know? _____

_____

_____

_____

_____

_____

What are your goals for this treatment? What do you expect to be able to change?
with regard to your pain and your life? If you are not working, do you plan to return to work, and how soon?
How hard are you willing to work to reach your goals?

_____

_____

_____

_____

_____

_____

To the best of my knowledge, this is complete and accurate.

Signed: _____ ***Date:*** _____