

**ANY QUESTIONS LEFT BLANK WILL BE CONSIDERED NEGATIVE REPOSSES**

**Patient Signature:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Date of Exam:** \_\_\_\_\_

**Male/Female** **Age:** \_\_\_\_\_ **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Pulse** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

How did you hear about our clinic?     Physician or other Health Care Professional     Friend or Family Member  
 Insurance                       Website                       Other

What are you seeing the doctor for today?  
\_\_\_\_\_

Your current condition is a result of:     Car Accident     Work Accident     Accident     Sports Injury     Unknown

Date of Injury: \_\_\_\_\_    How long have you had this problem? \_\_\_\_\_

List any diagnostic studies (MRI, CT, Bone Scan, Nerve Studies) you have had for this condition along with a date and location of where the studies was performed.

	TEST	DATE	FACILITY
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

***Personal Medical History***

Please check all that apply:

- Anemia
- Gout
- Cancer
- Osteoporosis
- Mental Illness
- Seizures
- High Blood Pressure
- Phlebitis
- Alcoholism
- AIDS
- Fibromyalgia
- Chronic Back Pain
- Depression
- Diabetic
- Bleeding/bruising tendency
- Stroke
- Heart Condition
- Irregular Heart Beat
- Heart Attack
- Asthma/Emphysema/wheezing
- Pulmonary Embolism (blood clot in lung)
- Blood Clots
- Sleep Apnea
- Kidney Transplant or Dialysis
- Rheumatoid Arthritis
- Stomach Ulcers

***Review of Systems***

Please check all that apply (recent or current only):

- Loss of Appetite
- Weight Loss
- Blurred Vision
- Ringing in Ears
- Pain with Swallowing
- Swelling of Feet
- Incontinence
- Balance Problems
- Coordination Problems
- Headaches
- Muscle Weakness
- Joint Stiffness/Swelling
- Nausea
- Constipation
- Fever
- Fatigue
- Double Vision
- Nose Bleeds
- Cold Hands or Feet
- Fainting
- Frequent Urination
- Memory Loss
- Dizziness
- Tremors
- Muscle Cramps
- Joint Pain
- Diarrhea
- Vomiting

**Other** \_\_\_\_\_

List any surgical procedures performed; start with the most recent surgery.

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

List all your current medications below. Please include any over the counter medication; including ibuprofen, Tylenol, vitamins and herb supplements. (If you have a list of your medications, please give to front desk to copy.)

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

Allergies to Medications:  Yes  No Please list: \_\_\_\_\_

Do you smoke?  Yes  No How much? \_\_\_\_\_ Do you drink alcohol?  Yes  No How often? \_\_\_\_\_

Are you employed?  Yes  No If yes, what is your occupation? \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed

Do you have children?  Yes  No

Education:  Junior High School  GED  High School  College  Graduated School

**DO NOT WRITE BELOW THIS LINE—OFFICE USE ONLY**

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**Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_