Your Personal Info

CONTACT

PATIENT LAST NAME

PATIENT FIRST NAME

PATIENT MIDDLE INITIAL

HOME STREET ADDRESS

HOME CITY

HOME STATE

HOME ZIP CODE

HOME PHONE

MOBLIE PHONE

EMAIL

Automated announcements including appointment reminders and information about clinic closure can be sent to you. Message charges may be assessed by your carrier. Please contact your carrier to inquire about any charges they might impose. What is your preferred method to receive this information?

○ TEXT ○ EMAIL ○ I DECLINE

ABOUT YOU

PATIENT DATE OF BIRTH

M M D D Y Y Y Y

PATIENT AGE

PATIENT SEX

○ MALE ○ FEMALE

WHAT NAME DO YOU PREFERRED TO BE CALLED?

PATIENT STATUS

○ SINGLE ○ MARRIED ○ PARTNERED ○ WIDOWED

EMERGENCY CONTACT

NAME

PHONE NUMBER

RELATIONSHIP TO PATIENT

EMPLOYMENT

PATIENT OCCUPATION

PATIENT EMPLOYER NAME

EMPLOYER STREET ADDRESS

EMPLOYER CITY

EMPLOYER STATE

EMPLOYER ZIP CODE

How did you hear about us? _____

Your Health Info

CHIEF COMPLAINT

What is the reason for your visit?

INTENSITY

Describe the severity of your complaint by marking the appropriate definition for each of the four categories below. Use the severity definitions consistently for each of the categories. If you have more than one complaint, complete each category by making a selection for each complaint. See the example below.

			Knee Pain		Back Pain				
○ 1. No Symptoms	○ 2. Slight Discomfort	○ 3. Does Not Affect Activity	☒ 4. Affects Personal Activities	○ 5. Prevents Personal Activities	☒ 6. Limits My Work Schedule	○ 7. Prevents All Working Activity	○ 8. Prevents All Activity	○ 9. Keeps Me Bedridden	○ 10. Causes Thoughts of Suicide

Mark the severity of your complaint as it is **right now**.

○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

Mark the severity of your complaint as it is on **average**.

○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

Mark the severity of your complaint as it is **at its best**.

○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

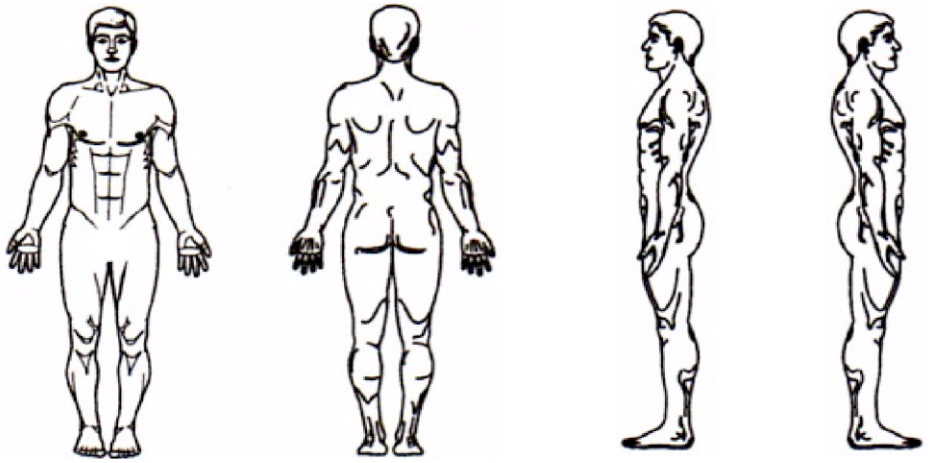
Mark the severity of your complaint as it is **at its worst**.

○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

SITE

Mark the areas of your complaint on the diagrams to the right. Include any descriptors or comments that you feel are important.

If your symptoms travel to other areas of your body, mark the diagrams to reflect how the symptoms seem to move.



REVIEW OF SYSTEMS

CONSTITUTIONAL	MUSCULOSKELETAL	NEUROLOGICAL	CARDIOVASCULAR	RESPIRATORY
○ Fever	○ Back Pain	○ Sudden Numbness	○ High Blood Pressure	○ Asthma
○ Weight Loss	○ Headaches	○ Sudden Headache	○ Heart Disease	○ COPD
○ Obesity	○ Extremity Pain	○ Loss of Sensation	○ Arterial Aneurysm	○ Common Cold
○ Loss of Appetite	○ Bone Demineralization	○ Confusion	○ Angina	○ Emphysema
○ Fatigue	○ Unstable Fracture	○ Dizziness	○ Irregular Heart Beat	○ Pneumonia
○ Anxiety	○ Spinal Infection	○ Slurred Speech	○ Bleeding Disorder	○ Cancer
○ Allergies	○ Spinal Bone Tumors	○ Loss of Balance	○ Heart Attack	○ Pneumothorax

EYES	E,N,M,T	GENITOURINARY	GASTROINTESTINAL	DISEASE HISTORY
○ Vision Trouble	○ Hearing Loss	○ Kidney Infection	○ Diarrhea	○ Stroke
○ Double vision	○ Tinnitus	○ Loss Bladder Control	○ Blood In Stool	○ Heart Attack
○ Night blindness	○ Vertigo	○ Urine Color Change	○ Abdominal Pain	○ Diabetes
○ Glaucoma	○ Nose Bleeds	○ Painful Urination	○ Liver/Gall Condition	○ Cancer
○ Cataracts	○ Dry Mouth	○ Urine Leakage	○ Nausea/Heartburn	○ HIV / AIDS
○ Discharge	○ Change in Taste	○ Urgency	○ Loss Bowel Control	
○ Droopy Eyelids	○ Bleeding Gums	○ Blood in Urine	○ Prostate Problems	

EXERCISE & NUTRITION

One of the important factors in our patient success is choosing patients committed to improving their healthy habits.

How committed are you to spending 10 to 15 minutes a day performing exercises that will enhance your results?

○ Not Interested at All	○ May Do it if I can Find the Time	○ I will Do it Most of the Time but Have Other Priorities	○ Fully Committed to Doing it No Matter What

Which of the following activities do you do on a weekly basis?

○ Running ○ Cycling ○ Swimming ○ Lift Weights ○ Yoga ○ Other

What healthy activities are you interested in beginning?

How many servings of fruits and vegetables do you eat each day?	○ 0	○ 1- 2	○ 3 - 4	○ 5 - 7	○ > 7
How many glasses of water do you drink a day?	○ 0	○ 1- 2	○ 3 - 4	○ 5 - 7	○ > 7
How many sugary beverages do you drink a week?	○ 0	○ 1- 2	○ 3 - 4	○ 5 - 7	○ > 7
How many alcoholic beverages do you drink a week?	○ 0	○ 1- 2	○ 3 - 4	○ 5 - 7	○ > 7

List the nutritional supplements that you are currently taking.

PAST HEALTH

List all of the prescription medications you are currently taking.

List all of the over-the-counter medications you are currently taking.

List all of the surgical procedures that you have had.

List all of the times you have been hospitalized.

List all significant past traumas that you have had.

Mark the following that are in your family history. ○ Heart Disease ○ Stroke/TIA ○ Diabetes ○ Cancer

PROVIDE OTHER INFORMATION IMPORTANT FOR US TO KNOW