NAME_____ DATE_____

**HISTORY**

1. What is your most significant problem[s] _____

   _____

2. Have you seen a physician _____ chiropractor _____ therapist _____ psychiatrist_____ for your condition.
   Did it help relieve the pain? YES NO
   Name[s] of those seen: _____

3. Please indicate the diagnostic test[s] you have had specific to your condition and write the results if you know them:
   Electromyogram[EMG]_____Date_____ Nerve Conduction Studies_____Date_____
   MRI/CT Scan_____Date_____ X-rays_____Date_____

4. Circle any treatments you have had for this pain/condition and indicate if it was helpful:
   Acupuncture_____ Epidural Injection_____ TENS Unit_____
   Occupational Therapy_____ Biofeedback_____ Aerobic Exercises _____
   Nerve Blocks_____ Home Exercise Program_____ Physical Therapy_____
   Psychological Counseling_____ Pain Medication_____

5. Do you now or have you ever had any of the following [Circle if YES and note any details]
   Chest Pain _____ Intestine/Stomach problems_____ Arrhythmia _____
   Kidney Disease _____ Asthma _____ Mental Health Condition_____
   Arthritis _____ Neuropathy _____ Osteoporosis _____
   Cancer _____ Prostate Condition _____ Coronary Artery Disease _____
   Kidney Disease _____ Diabetes _____ Seizure Disorder _____
   Diverticulosis _____ Stroke/TIA _____ Headaches _____
   Thyroid Condition ___ Heart Attack _____ Ulcers _____
   Ulcers _____ Hypertension _____ Urological Condition _____
   Hepatitis _____ HIV _____ Anemia _____

6. List all allergies to food or medicine: _____

   _____

7. List all medications you are presently taking. **Indicate dosage and prescriber**:

   _____ _____ _____

   _____ _____ _____

   _____ _____ _____

8. List all surgeries and date[s]: _____

_____

_____

9. Marital Status: Single_____ Married _____ Divorced _____ Widowed _____

Do you smoke: YES NO Number of cigarettes per day _____

If no, did you ever smoke: YES NO How long did you smoke _____

Do you drink alcohol: YES NO Number of drinks per day _____

Do you have a history of alcohol abuse: YES NO

Do you have a history of drug abuse/addiction: YES NO

10. Give a brief family history, including illnesses, and, if applicable, cause of death:

Mother_____ Father _____

Sister[s]_____ Brother[s]_____

11. **REVIEW OF SYSTEMS** [circle any positive findings]

| **GENERAL** | **GASTRO** | **ENDOCRINE** | **HEAD** | **SKELETAL** |
|---|---|---|---|---|
| Constipation | Nausea/vomiting | Temp. Intolerance | Headache | Stiffness |
| Weight changes | Bleeding | Frequent urination | Vision problems | Swelling |
| Weakness | Indigestion | Hunger | Glaucoma | Cramps |
| Fatigue | Pain | Thirst | | Spasms |
| Fever | Diarrhea | | **PSYCH** | |
| Difficult sleeping | Constipation | **HEARING** | Anxiety | **RESPIRATORY** |
| Night sweats | **GU** | Ear ache | Nervousness | Cough |
| Chills | Urinary tract infection | Dizziness | Tension | Phlegm |
| Sore throat | Menstrual problems | Nasal problems | Depression | Shortness of breath |
| | | | Mood swings | Tuberculosis |
| **NEURO** | **SKIN** | | Insomnia | Pneumonia |
| Fainting | Rashes | **CARDIAC** | **OTHER:** | |
| Paralysis | Lumps, breast/other | Chest pain/pounding | | |
| Weakness | Itching | Palpitations | | |
| Tremor | Hair changes | | | |
| Tingling | Nail changes | | | |
| Seizures | | | | |
| Memory problems | | | | |
| Numbness | | | | |