Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exam Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Patient History Onset Date:

Present complaint(s): (Circle areas of patient complaint and answer all questions following, do this for all regions of concern)

**Cervical**  Radiating? Y N If yes where to

Pain Rates (1 – 10 with 10 being extreme pain) How Often: Constant Frequent Intermittent Occasional

Description: Dull Sharp Achy Stiff Sore Tight Throbbing Numbness Tender Burning Tingling

**Thoracic**  Radiating? Y N If yes where to

Pain Rates (1 – 10 with 10 being extreme pain) How Often: Constant Frequent Intermittent Occasional

Description: Dull Sharp Achy Stiff Sore Tight Throbbing Numbness Tender Burning Tingling

**Lumbar Pelvic Sacral**  Radiating? Y N If yes where to

Pain Rates (1 – 10 with 10 being extreme pain) How Often: Constant Frequent Intermittent Occasional

Description: Dull Sharp Achy Stiff Sore Tight Throbbing Numbness Tender Burning Tingling

**Above Condition(s) Aggravated By:**

Walking Standing Running Sitting Climbing Stairs Lying Down Lifting Twisting Yard Work Exercising

Shoveling Snow Reaching Housework Prolonged Sitting Quick Movement Bending

**Above Condition(s) Better With:**

Adjustments Exercise Massage Stretching Walking Resting Lying Down Other:

What caused your condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date of Birth**:\_\_\_\_/\_\_\_\_/\_\_\_\_\_** Height:\_\_\_\_\_\_ Weight:\_\_\_\_\_\_lbs.

**Systems Review: Please check the following if you have complaints with any of the following systems?**

 [ ]  Neurological:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  Head & ENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  Cardiovascular:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  Respiratory:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  Gastrointestinal:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  Genitourinary:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  Endocrine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  Skin/Blood:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  No Complaints

**Past, Family and Social History:**

  **- Past Health History**

Allergies/Sensitivites:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Illnesses:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accidents:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**-Women’s Health:**

 - Currently Pregnant: [ ]  YES [ ]  NO

 - Currently Nursing: [ ]  YES [ ]  NO

 - Taking Birth Control: [ ]  YES [ ]  NO

 - Dysmenorrhea: [ ]  YES [ ]  NO

 - Irregular Periods: [ ]  YES [ ]  NO

 - Perform Regular Self Breast Exams: [ ]  YES [ ]  NO

 - Taking HRT: [ ]  YES [ ]  NO

 **- Social History:**

 - Work Habits: [ ] Sitting job [ ] Light labor [ ] Heavy Labor [ ] Full Time [ ] Part Time [ ] Unemployed

 [ ] Full Time Student [ ] Part Time Student

 - Social Habits: [ ] Drink Heavily [ ] Drink Moderately [ ] Drink Socially [ ] Smoke Cigarettes

 [ ] Use recreational drugs

 - Exercise Habits: [ ] Exercise Heavily [ ] Exercise Moderately [ ] Exercise Lightly

 - Diet and Nutrition: [ ] Strict Diet [ ] I try and stick to a diet [ ] unrestricted

Patient Signature: Date: