

Welcome to our office. To help us better evaluate your condition, please complete the following form. If you have any questions we will be glad to help you. Thank you.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Referred by: \_\_\_\_\_

List All Medications: \_\_\_\_\_

Do you have any drug allergies? Yes No If "Yes" please list: \_\_\_\_\_

List all surgeries you have had: \_\_\_\_\_

Location of complaint, pain or injury: \_\_\_\_\_

Date of injury/problem sustained or noticed: \_\_\_\_\_

**PAST MEDICAL HISTORY:**

*(Please circle any illnesses that you have been treated for. Items not circled are understood to be negative):*

- |                   |                             |                  |                  |               |
|-------------------|-----------------------------|------------------|------------------|---------------|
| Abnormal Bleeding | Pneumonia                   | Cancer           | Diabetes         | Heart Disease |
| Ulcer             | Hepatitis                   | Hypertension     | Kidney Disease   | Anemia        |
| Arthritis         | Osteoporosis                | Liver Disease    | Asthma           | Gout          |
| Anxiety           | Peripheral Vascular Disease | Emphysema        | Phlebitis        | Blood Clot    |
| Stroke            | Tuberculosis                | Polio            | Rheumatic fever  |               |
| Back/Neck Injury  | AIDS/HIV Positive           | Thyroid Disorder | Epilepsy/Seizure |               |

Other: \_\_\_\_\_ None: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: S M W D

Do you smoke tobacco? Yes No How many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you drink alcohol? Yes No Frequency: \_\_\_\_\_

Have you ever used or been dependent on drugs? Yes No Type: \_\_\_\_\_

**Family History:** *(Please circle any conditions that your family members have been treated for. Items not circled are understood to be negative):*

- |                   |                             |                  |                  |               |
|-------------------|-----------------------------|------------------|------------------|---------------|
| Abnormal Bleeding | Pneumonia                   | Cancer           | Diabetes         | Heart Disease |
| Ulcer             | Hepatitis                   | Hypertension     | Kidney Disease   | Anemia        |
| Arthritis         | Osteoporosis                | Liver Disease    | Asthma           | Gout          |
| Anxiety           | Peripheral Vascular Disease | Emphysema        | Phlebitis        | Blood Clot    |
| Stroke            | Tuberculosis                | Polio            | Rheumatic fever  |               |
| Back/Neck Injury  | AIDS/HIV Positive           | Thyroid Disorder | Epilepsy/Seizure |               |

Other: \_\_\_\_\_ None: \_\_\_\_\_

**Have you had any recent episodes of:** *(Please circle all that apply. Items not circled are understood to be negative):*

- |              |                |                     |              |                    |
|--------------|----------------|---------------------|--------------|--------------------|
| Fever        | Weight loss    | Shortness of Breath | Swelling     | Visual Changes     |
| Vomiting     | Diarrhea       | Rashes              | Hearing Loss | Chest pain         |
| Joint Pain   | Depression     | Frequent urination  | Hot Flashes  | Frequent Infection |
| Inflammation | Blood In Urine | Blood In Stool      | Anxiety      | NONE               |

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For Office Use Only:**

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_