Initial Medical History Intake Form

Name_____ **Age** ____ **Handedness: Right / Left** **Today's Date**____/____/____
Date of Birth ____/____/____ **Referred By:**_____

What problem/issue brings you here today?

When did it start? What were you doing?

List 3 activities you are now unable to do:

What makes it *worse*?

What makes it *better*?

What do you want to accomplish from today's visit?

Is this a Worker's Compensation Claim or is there litigation pending?			Yes	No	
What diagnostic tests have you had for this problem?	X-ray	MRI	CT scan	EMG	Bone scan
What treatments have you had for this problem?	Massage	Injections	Physical Therapy	Psychological	Chiropractic

Please make a *mark on the line* below to indicate the level of discomfort you have today.

No Pain —————————————————— Worst Pain Ever
0 1 2 3 4 5 6 7 8 9 10

Please describe what the pain feels like: Dull, Achy, Burning, Stabbing, Numbness, Tingling, Pulling, Cramping, Tightness
Please describe the time course of your pain: Constant, Comes and goes, Getting worse, Getting better, Staying about the same

Medications (Current) *With Doses*: *ALL* medications including Prescription, Over-the-Counter (ie: Advil, Vitamins)

Medical/Surgical History:
ALL Surgeries and medical conditions, **Diabetes**, Cancer, High blood pressure, Heart attack, Pacemaker, Arthritis, **Osteoporosis**.

Allergies to medicines:

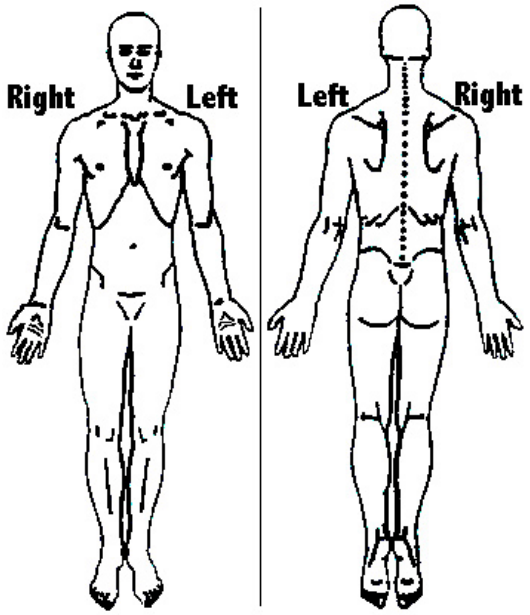
Family History:
Father: Living/Deceased Cancer, Heart Disease, Stroke, Diabetes, Hypertension
Mother: Living/Deceased Cancer, Heart Disease, Stroke, Diabetes, Hypertension

What do you do for exercise?
Do you use a cane or walker?

Tobacco use (cigarette, cigar, pipe, chew & how much)**:**	Current	Quit	Never
Illicit drug use (cocaine, marijuana, heroin, etc)**:**	Current	Quit	Never
Opioid use (hydro/oxycodone, morphine, etc)**:**	Current	Past	Never
History of substance abuse/addiction?	Current	Past	Never
Number of alcoholic beverages per week?			

Occupation:

Please draw where you have pain or discomfort



Employment status:	Full-time	Part-time	Light Duty	Off Duty due to injury	Full-time Parent	Not working	Retired

IF YES TO ANY OF BELOW CURRENTLY, PLEASE CIRCLE SYMPTOM

- **Night pain** **Fevers** **Unintentional weight loss**
- **Vision change** **Double vision**
- **Difficulty swallowing** **Headaches**
- **Chest pain** **Palpitations**
- **Shortness of breath** **Wheezing** **Coughing**
- **Nausea** **Vomiting** **Black stools** **Loss of control of stools**
- **Loss of control of urine** **Urinary frequency** **Urinary urgency**
- **New rashes** **Psoriasis**
- **Dizziness** **Weakness** **Numbness** **Tingling**
- **Depressed mood** **Suicidal thoughts** **Sleep problems** **Anxiety**
- **Low back pain** **Joint pain** **Joint swelling** **Muscle pain**

How many falls have you had in the last 12 months?
None
1 with / without injury
2+ with / without injury

Over 65 – Have you ever had a pneumonia shot? When?

For office use only:

Height: **Weight:**

BP:

Pulse:

Respirations: