

Patient: _____ **Date** _____

Marital status: _____ **Spouse:** _____

Date of Birth: _____ **Gender:** _____

Emergency Contact and Phone #: _____

Address: _____

For appointment reminders and office communication

Phone (Best number to reach you):

Work: _____ Cell: _____

Occupation: _____

Years there: _____

Email (Best email to reach you): _____

Would you prefer reminder appointment:

- Email
- Phone
- None

Referred by:

- #### Family member
- #### Friend
- #### Social Media/Online

Patient Health History

Allergies: No Yes What kind?

Medication	Dosage	Strength

Date	Surgeries

Family History (deceased)

Relationship	Cause of Death

Date	Hospitalization or Injury

Social History

Smoking status: Yes No How many day? Never smoker

Alcohol use: Yes No How many per week?

Caffeine use: Yes No How many per day?

Other drug use: Yes No

Exercise: Yes No What kind?

Patient Name _____ Date _____

General Health Symptoms (check only YES):

	Current	Past	Notes
Are you wearing any foot supports? Custom?			
Have x-rays of your spine ever been taken? If "Yes", when and where?			
Anemia			
Cancer			
Chicken Pox			
Depression/nervousness			
Diabetes			
Difficulty breathing			
Dizziness			
Epilepsy			
Fainting			
Fatigue			
Gout			
Headaches			
Low back pain			
Loss of sleep			
Loss of weight			
Multiple sclerosis			
Muscle or ligament tears			
Neck pain or stiffness			
Numbness			
Pain between shoulder blades			
Pain when coughing			
Pain when sneezing			
Pain when swallowing			
Swollen glands			
Ulcers			
Weakness			
Weight gain			
Bruise easily			
Rashes			
Sores			
Asthma			
Colds			
Coughing			
Deafness			
Decreased sense of smell			
Difficulty Breathing			

	Current	Past	Notes
Earache			
Ear discharge			
Ear noises			
Eye pain			
Failing eyesight			
Lung problems			
Ringin in the ear			
Sinus infection			
Sinus trouble			
Thyroid trouble			
Wheezing			
Arthritis			
Bursitis			
Hernia			
Jaw/TMJ pain or problems			
Low back pain			
Neck pain or stiffness			
Pain between the shoulders			
Sciatica			
Swollen joints			
Arteriosclerosis (hardening of the arteries)			
Blood clots			
Chest pain/pressure			
Heart Disease			
Heart murmur			
High blood pressure			
Low blood pressure			
Out of breath with mild effort			
Palpitations			
Poor circulation			
Rapid heartbeat			
Swollen ankles or hands			
Varicose veins			
Abdominal pain			
Change in bowel movements			
Colitis or Colon trouble			
Constipation			
Diarrhea			
Digestive problems			
Distention of abdomen			

Patient Name _____ Date _____

	Current	Past	Notes
Gall bladder trouble			
Gas or belching			
Hemorrhoids			
Indigestion			
Jaundice/liver trouble			
Pain over stomach			
Pain when straining at stools			
Poor appetite			
Vomiting/nausea			
Bed wetting			
Frequent urination			
Inability to control bladder			
Kidney infection or stones			
Painful urination			
Urinary tract infection			
Urinating at night			
Pregnant			
Irregular cycles			
Birth control pills			
IUD			
Breast soreness			
Hysterectomy...			
last gynecological exam...			
Medication for your cycle...			
Menopause since...			
Pain on urination			
Difficulty starting urinary flow			
Prostate trouble			
Pain or numb shoulder			
Pain or numb arms			
Pain or numb elbows			
Pain or numb hands			
Pain or numb head			
Pain or numb hips			
Pain or numb leg			
Pain or numb knees			
Pain or numb feet			
Pain or numb tailbone			
Pain or numb other			

Patient Name _____ Date _____

Main Complaint Area(s): pick two maximum

Neck, headache, midback/chest/ribs, lower back, hips, knees, ankle, Shoulder, wrists, fingers, jaw, other

Location				
How long have you had pain?				
Type of Pain?	Sharp	Dull/Achy	Numb/Pins Needles	Burning
Is it worse:	Morning	As the Day Progresses	Evening	Sleeping
What makes it better?	Nothing	Activity/Movement	Rest	Other
What makes it worse?	Nothing	Activity/Movement	Rest	Other
Pain level range 1=least amount 10=most pain	Best	Worst	Notes	
Does your pain radiate?	Yes	No	Notes	
How often is the pain?	Constant	Frequent	Intermittent	Rarely
Numb	Yes	No	Notes	
Weak	Yes	No	Notes	

Details:

Location				
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Type of Pain?	Sharp	Dull/Achy	Numb/Pins Needles	Burning
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Details: