Today's Date____________________________

Name: ____ Date of Birth: ______________ ☐ Male ☐ Female ☐ _____

Occupation: ____ ☐ Married ☐ Single ☐ Widowed

Handedness: ☐ Right ☐ Left Alcohol use? **Y / N** How much?_______________

Tobacco Use: ☐ Yes ☐ No Packs/Day: ____ # of years____ Former ☐ Date Quit: ______

Falls in the last year? ____Have any falls resulted in injury? ☐ Yes ____ ☐ No

Do you have: High Blood Pressure? ☐ Yes ☐ No Diabetes? ☐ Yes ☐ No Coronary Artery Disease? ☐ Yes ☐ No

Have you been vaccinated for COVID? ☐ Yes ☐ No ☐ Boosted

PRIMARY CARE PHYSICIAN____________________________ REFERRING PHYSICIAN____________________________________

REVIEW OF SYSTEMS

CONSTITUTIONAL:
- ☐ FATIGUE
- ☐ UNEXPLAINED WEIGHT LOSS

HEENT:
- ☐ VISUAL CHANGES

RESPIRATORY:
- ☐ KNOWN TB EXPOSURE
- ☐ SHORTNESS OF BREATH

CARDIOVASCULAR:
- ☐ CHEST PAIN
- ☐ EDEMA
- ☐ PALPITATIONS

GASTROINTESTINAL:
- ☐ ABDOMINAL PAIN
- ☐ CONSTIPATION
- ☐ DIARRHEA

GENITOURINARY:
- ☐ URINARY INCONTINENCE
- ☐ URINARY RETENTION

REPRODUCTIVE:
- ☐ SEXUAL DYSFUNCTION

INTEGUMENTARY:
- ☐ PRURITIS (ITCHING)
- ☐ RASH/HIVES

IMMUNOLOGIC:
- ☐ ENVIRONMENTAL ALLERGIES
- ☐ FOOD ALLERGIES

NEUROLOGICAL:
- ☐ DIZZINESS
- ☐ EXTREMITY NUMBNESS
- ☐ EXTREMITY WEAKNESS
- ☐ GAIT DISTURBANCE
- ☐ HEADACHE
- ☐ MEMORY LOSS
- ☐ SEIZURES
- ☐ TREMORS

PSYCHIATRIC:
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ INSOMNIA

MUSCULOSKELETAL:
- ☐ BACK PAIN
- ☐ JOINT PAIN
- ☐ JOINT SWELLING
- ☐ NECK PAIN

HEMATOLOGY / LYMPHATIC:
- ☐ EASY BLEEDING/BRUISING

METABOLIC / ENDOCRINE:
- ☐ COLD INTOLERANCE
- ☐ HEAT INTOLERANCE

YOUR MEDICAL HISTORY

- ☐ ALZHEIMER'S DISEASE/DEMENTIA
- ☐ ANGINA (CHEST PAIN)
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ CANCER________________________
- ☐ CARDIAC ARRYTHMIA/ATRIAL FIB
- ☐ COPD
- ☐ CORONARY ARTERY DISEASE/ HEART ATTACK
- ☐ DEPRESSION
- ☐ DIABETES
  - ☐ NON-INSULIN DEPENDENT
  - ☐ INSULIN DEPENDENT
- ☐ ELEVATED LIPIDS/HIGH CHOLESTEROL
- ☐ FIBROMYALGIA
- ☐ HEAD INJURY
- ☐ HEADACHES: MIGRAINE/TENSION
- ☐ HEPATITIS
- ☐ LIVER DISEASE
- ☐ HYPERTENSION
- ☐ OSTEOPOROSIS
- ☐ HIV AIDS
- ☐ PARKINSON DISEASE
- ☐ PERIPHERAL NERVE DISEASE (NEUROPATHY)
- ☐ POLIO
- ☐ RENAL DISEASE
- ☐ SEIZURE DISORDER
- ☐ SPINAL TUMOR
- ☐ STROKE
- ☐ THYROID DISEASE / DISORDER
- ☐ TREMOR
- ☐ OTHER ______________________

YOUR SURGICAL HISTORY
(PLEASE WRITE DATE NEXT TO ENTRY)

- ☐ ANGIOPLASTY / HEART STENT
- ☐ ARTHROSCOPY: KNEE/HIP/SHOULDER
- ☐ CABG (CORONARY ARTERY BYPASS

GRAFT)
- CARDIAC PACEMAKER
- CARPAL TUNNEL SURGERY (WRIST)
- CUBITAL TUNNEL SURGERY (ELBOW)
- CATARACT
- CRANIECTOMY
- GASTRIC BYPASS
- HERNIA REPAIR
- HIP REPLACEMENT R/L
- HYSTERECTOMY
- KNEE REPLACEMENT R/L
- MASTECTOMY
- SMALL BOWEL RESECTION
- THYROIDECTOMY
- TONSILLECTOMY
- CERVICAL (NECK) SURGERY ________
- LUMBAR (LOW BACK) SURGERY________
- ________________________________

PLEASE TURN OVER….

NAME: ______________________

YOUR FAMILY HISTORY

☐ ADOPTED OR UNKNOWN

MOM	DAD	
☐	☐	ALCOHOLISM
☐	☐	ALS
☐	☐	ASTHMA
☐	☐	CANCER___________________
☐	☐	CVA (STROKE)
☐	☐	DEMENTIA
☐	☐	DEPRESSION
☐	☐	DIABETES
☐	☐	HEADACHES
☐	☐	HEART DISEASE
☐	☐	HUNTINGTON'S CHOREA
☐	☐	HYPERTENSION
☐	☐	MULTIPLE SCLEROSIS
☐	☐	OSTEOPOROSIS
☐	☐	PERIPHERAL NERVE DISEASE (NEUROPATHY
☐	☐	PERIPHERAL VASCULAR DISEASE
☐	☐	SCHIZOPHRENIA
☐	☐	SEIZURE DISORDER
☐	☐	OTHER ________________________________

REGARDING THE PROBLEM THAT YOU ARE HERE TO SEE THE DOCTOR FOR:

IF YOU HAVE PAIN, WHERE IS IT THE WORST?

WAS IT CAUSED BY A SPECIFIC INCIDENT OR ACCIDENT?

APPROXIMATELY WHEN DID YOUR SYMPTOMS START?

OVERALL, IS YOUR PAIN THE SAME, BETTER OR WORSE THAN IT BEGAN?

IF YOU HAVE PAIN, DO SYMPTOMS RADIATE OR MOVE ELSEWHERE? IF SO, WHERE?

WHAT MAKES THE SYMPTOMS WORSE?

WHAT MAKES THE SYMPTOMS BETTER?

HAVE YOU EVER HAD A NERVE AND MUSCLE TEST (EMG/ELECTROMYOGRAM) BEFORE? _______________

PLEASE MARK CONSERVATIVE TREATMENTS THAT HAVE BEEN TRIED:

☐ Oral medication (NSAIDS, ANALGESICS) ☐ TOPICAL MEDICATION ☐ ICE OR HEAT ☐ SPLINTS/BRACES/ WALKER

☐ INJECTION(S) Where?___________________ When? _________________

☐ PHYSICAL THERAPY WHERE?_______________________ WHEN/FOR HOW LONG?_____________

☐ HOME EXERCISE PROGRAM ☐ CHIROPRACTIC CARE ☐ ACUPUNCTURE/MASSAGE

☐ RECENT IMAGING where was it done? ___________________