**Health History**

**Please list each of your areas of pain separately**

**Complaint #1**Reason for appointment / Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date condition started \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is this injury related? YES NO

Describe the location of the pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Radiating Symptoms**Do your symptoms radiate from the primary area? YES NO

If yes, where do the symptoms radiate to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain Severity: 10 is the worst pain imaginable, and 0 is no pain. Please circle the appropriate number for your pain over the last 2 weeks:**

Today: 0 1 2 3 4 5 6 7 8 9 10 Best: 0 1 2 3 4 5 6 7 8 9 10

Worst: 0 1 2 3 4 5 6 7 8 9 10

Would you describe your pain as: Constantly Frequent Occasional Seldom

**How would you describe the quality of your pain?** (Check all that apply)

Achy Annoying Burning Constricting Dull Intense Sharp Sharp with movement

Shooting Stabbing Stiff Throbbing Unbearable Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What makes your pain diminish?** (Check all that apply)

"Popping" the joints Bracing/taping Exercise/Activity Heat Ice Laying Massage/Rubbing

Nothing Over the counter medication Prescription Medication Rest Sitting Standing

Stretching Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What makes your pain WORSE?** (Check all that apply)

Bearing down Bending Coughing Driving Laying Down Lifting Movement of the head

Movement of the low back Pushing Running Sexual Intercourse Sitting Sneezing Standing

Walking Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you have had any change in your bladder function, do you:**

Have a loss on sensation around groin or buttocks Have loss of control or accidents Have problems with

sexual function Urinate more frequently Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Numbness/Tingling (pins and needles):**

Do you experience or have you recently experienced numbness and/or tingling anywhere? YES NO

If YES, please describe where and when you feel these symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Complaint #2**

Reason for appointment / Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date condition started \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is this injury related? YES NO

Describe the location of the pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Radiating Symptoms**

Do your symptoms radiate from the primary area? YES NO

If yes, where do the symptoms radiate to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain Severity: 10 is the worst pain imaginable, and 0 is no pain. Please circle the appropriate number for your pain over the last 2 weeks:**

Today: 0 1 2 3 4 5 6 7 8 9 10 Best: 0 1 2 3 4 5 6 7 8 9 10

Worst: 0 1 2 3 4 5 6 7 8 9 10

Would you describe your pain as: Constantly Frequent Occasional Seldom

**How would you describe the quality of your pain?** (Check all that apply)

Achy Annoying Burning Constricting Dull Intense Sharp Sharp with movement

Shooting Stabbing Stiff Throbbing Unbearable Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What makes your pain diminish?** (Check all that apply)

"Popping" the joints Bracing/taping Exercise/Activity Heat Ice Laying Massage/Rubbing

Nothing Over the counter medication Prescription Medication Rest Sitting Standing

Stretching Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What makes your pain WORSE?** (Check all that apply)

Bearing down Bending Coughing Driving Laying Down Lifting Movement of the head

Movement of the low back Pushing Running Sexual Intercourse Sitting Sneezing Standing

Walking Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you have had any change in your bladder function, do you:**

Have a loss on sensation around groin or buttocks Have loss of control or accidents Have problems with

sexual function Urinate more frequently Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Numbness/Tingling (pins and needles):**Do you experience or have you recently experienced numbness and/or tingling anywhere? YES NO

If YES, please describe where and when you feel these symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General History**Please give us information regarding your Primary Care Physician (PCP), and enter his or her information in as the first Medical Doctor listing below. The last name of provider must be entered.

Who is your Primary Care Physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last visit to PCP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for visit to PCP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you work on a computer? YES NO Hours per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Doctors (Last Name of Provider Must Be Entered)**1. Salutation \_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial \_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Salutation \_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial \_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Salutation \_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial \_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Diabetic**When were you diagnosed as diabetic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of diagnosis? Diabetes Type 2 Diabetes Type 1 Insulin Dependent Non-Insulin Dependent

Blood sugar \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last blood sugar \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Self-monitoring blood sugar? YES NO

HbA1c \_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_ HbA1c Time \_\_\_\_\_\_\_\_\_\_\_\_ HbA1c Date \_\_\_\_\_\_\_\_\_\_\_\_

**Health Review**Please review the list of symptoms and diseases below. For each condition that you currently have, or for each condition that you have a significant history, please check that box. This gives us important information regarding your general health and disease issues.

**Endocrine** **Negative** Adrenal Gland Disorders Diabetes - Diet Controlled Diabetes - Gestational

Diabetes Type I Diabetes Type II Hyperthyroidism Hypoglycemia Hypothyroidism Prediabetes

Test Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hematologic/ Lymphatic**

**Negative**  Anemia Blood Disorders enlarged Lymph Nodes Hemochromatosis Hemophilia

Leukemia Lyme Disease Lymphoma Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular/Heart**

**Negative** Angina Arrhythmia Bypass Graft Bypass Surgery Chest Pain Congestive Heart Failure

Coronary Artery Disease Cyanosis Heart Disease Heart Murmur Heart Palpitation High Blood

Pressure Controlled High Blood Pressure Uncontrolled High Cholesterol History of Heart Disease

Irregular Heart Beat Mitral Valve Prolapse Pacemaker Shortness of Breath Stent Stroke

Valve Replacement Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neurological**

**Negative** Bell’s Palsy Cranial Nerve Palsy Dizziness Epilepsy Involuntary Movement Migraines

Paralysis Seizures Stroke TIA Vertigo Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ears, Nose, Throat**

**Negative** Chronic Colds Chronic Sinusitis Chronic Strep Infections Dentures Ear- Itching

Ear Infections Ear Pain Hearing Aid Both Ears Hearing Aid Left Ear Hearing Aid Right Ear

Hearing Loss Left Ear Hearing Loss Right Ear Mouth Sores Nose Bleeds Partial Hearing Loss Both

Ears Partial Hearing Loss Left Ear Partial Hearing Loss Right Ear Ringing in Ears Runny Nose

Sinus Pain Sinusitis Sore Throat Stuffy Nose Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Respiratory/Lungs**

**Negative** Asthma Bronchitis Chronic Bronchitis Chronic Cough Collapsed Lung Left Collapsed

Lung Right COPD Emphysema Lung Cancer Pleurisy Pneumonia Sarcoid Shortness Of Breath

Tuberculosis Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Stomach/Intestines**

**Negative** Abdominal Pain Bowel Cancer Change In Appetite Constipation Crohn's Disease

Diarrhea Difficulty Swallowing Diverticulitis Esophagitis Frequency Of Bowel Movements

Gall Bladder Disease Gastric Reflux Heartburn Hemorrhoids Hepatitis Type A Hepatitis Type B

Hepatitis Type C Hernia Indigestion Irritable Bowel Syndrome Jaundice Nausea Pancreatitis

Stomach Cancer Ulcerative Colitis Ulcers Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Integumentary/Skin**

**Negative** Basal Cell Carcinoma Bruising Changes in Color/Pigmentation Changes in Nails/Hair

Dermatitis Dryness Eczema Excessive Sweating Itching Psoriasis Skin Cancer Skin Rash

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bones/Joints/Muscles**

**Negative** Arthritis Back Pain Bone Cancer Cerebral Palsy Gout Joint Pain Juvenile Rheumatoid

Arthritis Limited Range Of Motion Multiple Sclerosis Muscle Pain Muscular Dystrophy Neck Pain

Polymyalgia Rheumatoid Arthritis Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergic/Immunologic**

**Negative** Allergy Shots HIV Immune Disorder Lupus Seasonal Allergies Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatric**

**Negative** Depression Panic Episodes Stress Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Constitution**

**Negative** Chills Fatigue Fever Insomnia Sleeping All the Time Sudden Weight Gain Sudden Weight Loss Weakness Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Genitals/Kidney/Bladder**

**Negative**  Bladder Infections Bladder Repair Bladder Spasms Cervical Cancer Changes In Color Of

Urine Dialysis Endometriosis Frequent Urination Incontinence Kidney Failure Kidney Infections

Kidney Stones Kidney Transplant Menopause Symptoms Ovarian Cancer Ovarian Cysts

Prostate Cancer Recurrent Urinary Tract Infections Renal Cancer Renal Stricture Sexually

Transmitted Disease Testicular Cancer Uterine Cancer Uterine Fibroids Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other:** ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical Conditions:**  Arthritis Asthma Cancer COPD Heart Disease High Cholesterol

Hypertension Kidney Disease Thyroid Problem

Details of Past Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medications  
Name Date Started (mm/dd/yyyy) Use**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Allergies  
Name of Allergy Reaction Severity Onset Type**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Anaphylactic Shock Hives Rash  Nausea/Vomiting | Mild Moderate  Severe Unspecified | 6 months 1 year 2years Childhood Seasonal | Cosmetic Drug Food Insect  Environmental |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Anaphylactic Shock Hives Rash  Nausea/Vomiting | Mild Moderate  Severe Unspecified | 6 months 1 year 2years Childhood Seasonal | Cosmetic Drug Food Insect  Environmental |

**Surgeries   
Name of Procedure Date of Surgery (mm/dd/yyyy) Surgeon**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Social History  
Do you smoke?** N/A Chewing Tobacco Cigarettes, 1 pack/day Cigarettes, 1-3 pack/day

Cigarettes, <1 pack/day Cigarettes, Discontinued Cigars, 3 or more/week Cigars, Occasional Pipe

**Do you drink alcohol?** N/A Beer, 3 or less per week Beer, 4 or more per week Liquor, 3 or less per week

Liquor, 4 or more per week Social Wine, 3 or less per week Wine, 4 or more per week

**Recreational Drug Use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Hobbies:**  Fishing Piano Pilot Sewing Sports Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you exercise?**  1 time per week 2 times per week 3 times per week 4 times per week 5 or more times per week Do not exercise

**What activities do you do? (Check all that apply)**

Cycling Dancing Elliptical Jogging Pilates Running Swimming Walking Weight Training

Yoga Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Would you consider yourself to be…?**  Normal Weight Obese Overweight Severely Obese Underweight

**Have you seen a Chiropractor before?**  YES NO

Who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When: **\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_**

Reason for visit Altered gait pattern Blurred vision Burning Decreased ability to perform recreational

activities Decreased ability to perform work activities Decreased awareness of posture Decreased balance

Decreased cardiovascular endurance Decreased flexibility Decreased functional ability Decreased ROM

Decreased segmental mobility Decreased strength Difficulty urinating Difficulty walking Eye Pain

Headache Increased soft tissue tone Loss of grip strength Numbness of tingling Pain Stiffness

Pelvic asymmetry with kinetic testing Radicular symptoms Swelling Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your previous chiropractor take before and after x-rays? YES NO