NAME: _____ OCCUPATION: _____
LEISURE ACTIVITIES:

❑ Yes ❑ No Are you latex sensitive? Other allergies:_____
❑ Yes ❑ No Have you declared the Advanced Clinical Directive of Do Not Resuscitate?

Check (√) any of the following that you are currently under the care of:

❑ Medical doctor (MD/DO) ❑ Dentist ❑ Psychiatrist/Psychologist ❑ Physical Therapist ❑ Chiropractor
❑ Other _____
If you have seen any of the above during the past 3 months, please describe the reason (illness, medical condition, check-up, etc.):

_____

Check (√) any of the following that YOU have a history of:

❑ Circulation problems ❑ Multiple sclerosis ❑ Hepatitis
❑ Asthma ❑ Long term corticosteroid use ❑ Tuberculosis
❑ Stomach ulcers ❑ Blood clots ❑ Other_____
❑ Thyroid problems ❑ Osteoporosis

Please list any significant injuries, surgeries, and hospitalizations, including the approximate date:

1.) _____ 3.) _____
2.) _____ 4.) _____

Check (√) any of the following that YOU or anyone in your IMMEDIATE FAMILY (parent, brother, sister) has ever been treated for:

❑ SELF ❑ FAMILY Depression
❑ SELF ❑ FAMILY Stroke
❑ SELF ❑ FAMILY Kidney disease
❑ SELF ❑ FAMILY High blood pressure
❑ SELF ❑ FAMILY Diabetes
❑ SELF ❑ FAMILY Chemical dependency (Alcoholism)
❑ SELF ❑ FAMILY Inflammatory arthritis (Rheumatoid)
❑ SELF ❑ FAMILY Cancer, Type: _____
❑ SELF ❑ FAMILY Heart problems/Pacemaker, Type:_____

Please answer the following questions regarding your CURRENT symptoms:

Body region(s) affected:_____
Date that symptoms began (approximately): _____
❑ Yes ❑ No Are symptoms due to a specific injury?

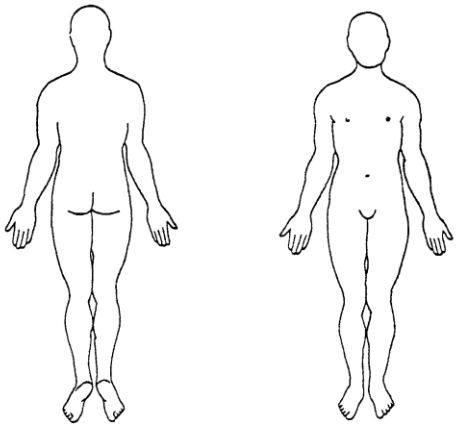
_____

Pain scale: 0-10 (No pain = 0, Worst pain imaginable = 10)
Current rating: _____ /10, at worst:_____ /10, at best:_____ /10
Treatments for current problem, please include medications: _____

_____

Check (√) any of the following diagnostic tests completed for your current condition: ❑X-rays ❑MRI ❑Other:_____

Please mark the areas where you have pain on the body chart.



Check (√) any of the following statements that are TRUE:

❑ During the past month I have been feeling down, depressed, or hopeless.
❑ During the past month I have been bothered by having little interest or pleasure in doing things.
❑ I have been threatened, hurt, made to feel afraid/ humiliated by someone close to me.

Check (√) any of the following that are NEW, UNUSUAL or ATYPICAL for you:

❑ Weight loss/gain
❑ Nausea/vomiting
❑ Dizziness/lightheadedness
❑ Fatigue
❑ Weakness
❑ Fever/chills/sweats
❑ Numbness or tingling
❑ Tremors
❑ Seizures
❑ Double vision
❑ Loss of vision
❑ Eye redness
❑ Skin rash
❑ Problems sleeping
❑ Sexual difficulties
❑ Night sweats
❑ Hearing problems
❑ Stress at home or work
❑ Pregnant or think you may be
❑ Blood in the urine
❑ Urinary incontinence
❑ Problems urinating (difficulty starting, painful etc.)
❑ Blood in stool
❑ Constipation/diarrhea
❑ Heartburn/indigestion
❑ Difficulty swallowing
❑ Heart racing in your chest
❑ Arm/leg swelling
❑ Regular cough
❑ Difficulty breathing
❑ Excessive bleeding
❑ Post menopause
❑ Joint/muscle swelling
❑ Easy bruising

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