1 Medications

1) _____
2) _____
3) _____
Pharmacy Name: _____
Pharmacy Phone: (____) _____

☐ None

Surgeries

1) _____
2) _____
3) _____
4) _____
5) _____

Other ☐ _____ ☐ None

Fractures

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

_____

☐ None

2 Family History

Autoimmune Dis.	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	☐ Other_____	
Bleeding Disorder	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No		
Clothing Disorder	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No		

3 Medical History

Name and address of other doctor(s):

_____

Date of Last: Physical Exam _____ Spinal X-ray _____ Spinal Exam _____ Chest X-ray _____
MRI, CT-Scan, Bone Scan _____ Blood Test _____ Urine Test _____

Mark "Yes" or "No" to indicate whether you have experienced each of the following and complete the information below:

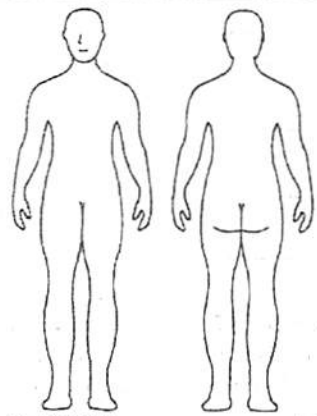
AIDS/HIV	☐ Yes ☐ No	Chemical Depend./		Hernia	☐ Yes ☐ No	**Pinched Nerve**	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Alcoholism	☐ Yes ☐ No	**Herniated Disk**	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No
Anxiety/Depression	☐ Yes ☐ No	**Clotting Disorder**	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheum. Arthritis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Eating Disorder	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	STD	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Autoimmune Dis.	☐ Yes ☐ No	**Epilepsy/Seizure Dis.**	☐ Yes ☐ No	**MS**	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Are you pregnant?	☐ Yes ☐ No	If yes, how many weeks? _____				☐ Other _____	

4 Primary Complaint

*Please note **ONE** complaint in the following section. The Primary Complaint is your chief complaint or most problematic concern at this time that brought you in today.*

☐ Denied

Primary complaint: _____
Please describe the condition: _____
When did your symptoms first appear? _____
Most recent occurrence date: _____
What do you think caused this problem? _____
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown
Mark an X on the picture where you have pain, numbness or tingling:



Rate the severity of your pain ... at its worst: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
... at its least severe: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
(please circle) ... at present moment: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Type of pain: ☐ **Sharp** ☐ Dull ☐ **Throbbing** ☐ **Numbness** ☐ Aching ☐ **Shooting**
☐ **Burning** ☐ **Tingling** ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other_____

Does the pain travel from one location to another? From where to where? _____
How often do you have this pain? ☐ Constantly ☐ Comes and goes ☐ Infrequently ☐ Daily ☐ Weekly ☐ Monthly
Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐ N/A
Which activities are affected by this? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ N/A ☐ Other_____
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down
Past Treatments: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____
Were they successful? ☐ Yes ☐ No
Pain worsens with: _____ Pain improves with: _____
Notes: _____