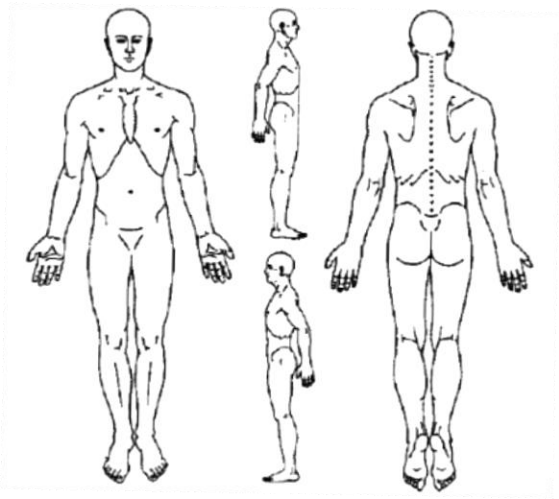
Name: _____ **DOB:** _____ **Preferred name:** _____

Email: _____ **Preferred phone # contact:** _____

Chief complaint(s): (Check all that apply)

[ ] Pain	[ ] Weakness/Fatigue	[ ] Dizziness	[ ] Headaches
[ ] Stiffness/Swelling	[ ] Numbness/Tingling	[ ] Falls/Balance Issues	[ ] Other: _____

Please draw on the body diagram, where your symptoms are located:



Please indicate the intensity of your symptoms
0 = none 10= worst imaginable

BEST

0 1 2 3 4 5 6 7 8 9 10

WORST

0 1 2 3 4 5 6 7 8 9 10

PRESENT

0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms worse: _____

What makes your symptoms better: _____

Do you currently take any medications or supplements?

[ ] Yes [ ] No *-If Yes, please list below or provide a list to be photocopied

Medication/Supplement	Reason for Use	Dose & Frequency

Have you ever had an allergic reaction to a material or medication?

[ ] Yes [ ] No *-If Yes, please list: _____

Do you currently use tobacco products?

[ ] Yes [ ] No

Have you ever had any of the following conditions? (Check all that apply)

Cardiovascular
[ ] Heart Disease
[ ] Heart Attack
[ ] Pacemaker/Defibrillator
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] High Cholesterol
[ ] Blood Clots
[ ] Circulation Disorders

Musculoskeletal
[ ] Arthritis
[ ] Headaches/Migraines
[ ] Osteoporosis/Osteopenia

Respiratory
[ ] Asthma
[ ] COPD
[ ] Emphysema
[ ] Sleep Apnea

Neurologic
[ ] Stroke
[ ] Spinal Cord Injury
[ ] Head Injury/Concussion
[ ] Multiple Sclerosis
[ ] Parkinson's Disease
[ ] Seizures
[ ] Dementia

Miscellaneous
[ ] Cancer
[ ] Diabetes
[ ] Depression/Anxiety
[ ] Kidney Disorder
[ ] Liver Disorder
[ ] Thyroid Disorder
[ ] Gastrointestinal Disorder
[ ] Skin Disorder
[ ] Lymphedema
[ ] Fibromyalgia
[ ] Bowel/Bladder Dysfunction
[ ] Vision/Hearing Impairments
[ ] Infectious Disease

Other
[ ] _____

Check all surgeries you have had, and describe:
[ ] Cardiac Surgery _____
[ ] Abdominal Surgery _____
[ ] Organ Surgery _____
[ ] Brain Surgery _____
[ ] Spine Surgery _____
[ ] Shoulder/Arm Surgery _____
[ ] Leg Surgery _____
[ ] Other _____

What tests have you had related to your current symptoms:
[ ] X-ray [ ] MRI [ ] CT Scan [ ] Other: _____

Do you have any of the following in your body?
[ ] Metal Rods or Pins [ ] Staples or Screws [ ] Artificial Joints [ ] Other: _____

Are you currently (or is there a chance that you are) pregnant?
[ ] Yes [ ] No

To the best of my ability, I have included all pertinent medical information.

Patient/Guardian signature: _____ **Date:** _____

Medical history reviewed by clinician and used in determining the plan of care.

Clinician signature: _____ **Date:** _____ **Time:** _____