NAME: __________________________________________________________ DATE: __________________
PRIMARry CARE PHYSICIAN: ______________________ HOW DID YOU HEAR ABOUT OUR OFFICE?: ______________________

INdicate the area of primary symptoms below: xxx = burning, /// = sharp stabbing, (( = aching

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Mark ‘X’ on the line: No pain ----------------------------------------------- Worst pain imaginable

What makes it better?-------------------------------------------------------- What makes it worse?
I feel it: ___ Constantly ___ Daily ___ Several times a week ___ Several times a month
Getting: ___ Better ___ Worse ___ Same

How long have you had symptoms? If specific injury, date of injury and how:

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Y N Workplace injury? Y N Lawsuit involved?
Y N Time off work? Y N Previous injury?

What have you tried for it so far?

Y N Doctor:
Y N Medication:
Y N Physical Therapy:
Y N Orthotics/Braces:
Y N Injections:
Y N Other:

What type of activities are being affected?

Y N Home:
Y N Work:
Y N Walking:
Y N Running:
Y N Recreation:
Y N Other:
ALLERGIES
List all known allergies:________________________________________________________________________________
__________________________________________________________________________________________________

PAST MEDICAL HISTORY
What other medical problems do you have?________________________________________________________________
__________________________________________________________________________________________________

PAST SURGICAL HISTORY
What surgeries have you had?___________________________________________________________________________
__________________________________________________________________________________________________

MEDICATIONS
Please list all medications and dose that you take:_________________________________________________________
__________________________________________________________________________________________________

SOCIAL HISTORY
What do you do for a living?_______________________Who do you live with?__________________________________
Smoking:___No___Used to___Yes, ___packs per day x ___years / Drinking:___No___Yes, ___drinks per week

FAMILY HISTORY
Any significant medical problems that run in your family?___________________________________________________
__________________________________________________________________________________________________

REVIEW OF SYSTEMS: Check all that apply, or check here if all negative_____

<table>
<thead>
<tr>
<th>Constitutional</th>
<th>Hematologic</th>
<th>Cardiovascular</th>
<th>Respiratory</th>
<th>Gastrointestinal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight loss</td>
<td>Blood clots</td>
<td>Chest pain</td>
<td>Short of breath</td>
<td>Heartburn / Reflux</td>
</tr>
<tr>
<td>Weight gain</td>
<td>Easy bleeding</td>
<td>Palpitations</td>
<td>Cough</td>
<td>Ulcers</td>
</tr>
<tr>
<td>Fevers/chills</td>
<td>Anemia</td>
<td>Fainting</td>
<td>Sleep apnea</td>
<td>Hepatitis</td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td>High blood pressure</td>
<td>Smoke cigarettes</td>
<td>Nausea</td>
</tr>
<tr>
<td>Hospitalization</td>
<td></td>
<td></td>
<td>Asthma</td>
<td>Vomiting</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Musculoskeletal</th>
<th>Endocrine</th>
<th>Neurologic</th>
<th>Psychiatric</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint pain / swelling</td>
<td>Diabetes</td>
<td>Visual changes</td>
<td>Depression</td>
<td>Kidney problems</td>
</tr>
<tr>
<td>Muscle weakness</td>
<td>Excessive thirst</td>
<td>Dizziness</td>
<td>Anxiety</td>
<td>UTI</td>
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<tr>
<td>Gout</td>
<td>Thyroid disorder</td>
<td>Balance difficulties</td>
<td>Substance abuse</td>
<td>MRSA</td>
</tr>
<tr>
<td>Rheumatoid</td>
<td>Heat intolerance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broken bones</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>