Chief complaint (why you are here):

_____

When did it happen: _____

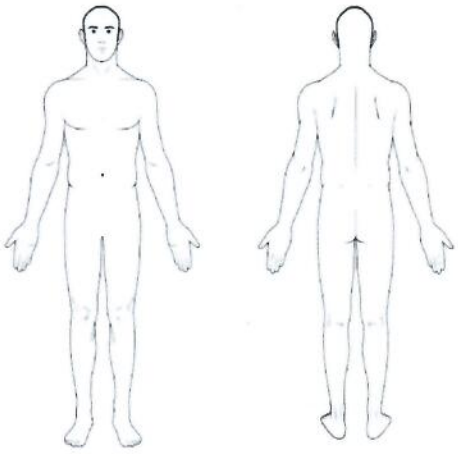
How did it happen: _____

_____

Describe the pain: _____

Previous treatments: _____

Previous studies: X-rays CT scans MRI



Rate the pain: 0 1 2 3 4 5 6 7 8 9 10

Social History:

Stress level: 1 2 3 4 5 6 7 8 9 10

Hours of sleep a night: 1 2 3 4 5 6 7 8 9 10

Alcohol use: _____ daily _____ weekly

Smoker: never former current

Personal goals:

What are your goals treating this:_____

_____

How long do you think this needs treated: _____

_____

How it affects your life:_____

_____

Please circle for each current or past symptoms

General symptoms:

Dizziness
Fatigue
Headache
Loss of sleep
Night sweats
Numbness or pain

Muscles/joints:

Backache
Foot trouble
Painful tail bone
Stiff neck
Swollen joints

GI:

Constipation
Diarrhea
Nausea
Stomach pain
Vomiting
Heart burn
Bloody stools
Acid reflux
Irritable Bowel

Cardiovascular:

High blood pressure
Strokes
swollen ankles
Chest pain

Urinary:

Bed Wetting
Blood in Urine
Frequent Urination
Kidney infection
Painful Urination
Prostate Trouble

Respiratory:

Chest Pain
Chronic cough
difficulty breathing

Eye/Ear/Throat:

Blurred vision
Thyroid Problems
Ringing in ears

For Females:

Cramps
Irregular Cycle
Painful Periods
Pregnant Now?

Diseases:

Diabetes Other:_____
Cancer
Heart Disease

Family HX:

Diabetes: Mother Father
Cancer: Mother Father
Heart Disease: Mother Father