

Please take your time on providing the information requested.  
The more precise the data, the better we can proceed with adequate treatment plans.

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_ Chart #: \_\_\_\_\_

Your work is: \_\_\_\_\_ Your Physician: \_\_\_\_\_

You were referred by: \_\_\_\_\_ Your phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Allergies: \_\_\_\_\_

For provider use only

What is your main problem?		
When did it start?		
How did it start? Suddenly ( ) Gradually ( ) Accidentally ( )		
What makes you feel worse?		
What makes you feel better?		
Current Medications:  (Include vitamins, herbal remedies, etc.)		
Medications you have used before:		
Current providers that treat you:  (Medical Doctors, Chiropractors, Therapists, etc.)		
What treatments have you had and what has worked?  (Physical Therapy, Chiropractics, Acupuncture, etc.)		

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Do you have other health problems?																																			
Family Diseases: (Cancer, heart disease, high blood pressure, stroke, diabetes, etc.)																																			
Hospitalizations and/or surgeries:																																			
Diagnostic studies you have had: (X-rays, MRIs, CT Scans, etc.)																																			
Habits:	Smoker: Yes ( ) No ( ) Alcohol: Yes ( ) No ( ) Coffee: Yes ( ) No ( ) Diet:																																		
What exercise do you do and with what frequency?																																			
Review of systems: (Circle what applies to you at present.)	<table border="0"> <tr> <td>Headaches</td> <td>Visual changes</td> <td>Hearing changes</td> </tr> <tr> <td>Heart disease</td> <td>Stroke</td> <td>Bladder problems</td> </tr> <tr> <td>Skin problems</td> <td>Fatigue</td> <td>Digestive problems</td> </tr> <tr> <td>Depression</td> <td>Poor sleep</td> <td>Thrombophlebitis</td> </tr> <tr> <td>Muscle pain</td> <td>Joint pain</td> <td>Blood sugar problems</td> </tr> <tr> <td>Constipation</td> <td>Diarrhea</td> <td>High blood pressure</td> </tr> <tr> <td>Anxiety</td> <td>Easy bruising</td> <td>Bleeding problems</td> </tr> <tr> <td>Hepatitis</td> <td>Tuberculosis</td> <td>Wear a pacemaker</td> </tr> <tr> <td>HIV positive</td> <td>Pregnant</td> <td>Weight changes</td> </tr> <tr> <td>Chest pains</td> <td>Sinus allergies</td> <td>Swollen joints or extremities</td> </tr> <tr> <td>Back pain</td> <td>Sore throat</td> <td>Dry mouth or eyes</td> </tr> </table>	Headaches	Visual changes	Hearing changes	Heart disease	Stroke	Bladder problems	Skin problems	Fatigue	Digestive problems	Depression	Poor sleep	Thrombophlebitis	Muscle pain	Joint pain	Blood sugar problems	Constipation	Diarrhea	High blood pressure	Anxiety	Easy bruising	Bleeding problems	Hepatitis	Tuberculosis	Wear a pacemaker	HIV positive	Pregnant	Weight changes	Chest pains	Sinus allergies	Swollen joints or extremities	Back pain	Sore throat	Dry mouth or eyes	
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Substance Abuse:	Have you or any family member had problems with drug addiction to prescribed or illegal drugs? Yes ( ) No ( ) Alcohol abuse? Yes ( ) No ( ) If yes to either question, please explain:																																		
Rate the intensity of your problem as it is today:	<table border="0"> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>6</td> <td>7</td> <td>8</td> <td>9</td> <td>10</td> </tr> <tr> <td colspan="5">None</td> <td colspan="5">Worse than ever</td> </tr> </table>	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	1	2	3	4	5	6	7	8	9	10	None					Worse than ever								
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Do you think that you may have any condition that may contraindicate physical therapy, acupuncture, or any other procedure? ( ) Yes or ( ) No. If you answered yes, please discuss this with your provider before starting with treatment.

Reviewing Provider's Signature: \_\_\_\_\_