General Information:

Name: _____ DOB: _____

Address: _____ City: _____ State: _____

ZIP Code: _____ Phone: _____ Cell: _____

Email: _____ SSN: _____

Gender: M F Other Weight: _____ Height: _____

Marital Status: Single Married Common-law Separated Divorced Widowed

Spouse's Name: _____Number of Children: _____

Names & Ages: _____

Emergency Contact Info:

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

☐ I authorize this clinic to leave voice messages on all answering devices and to send text messages to capable devices.

☐ I authorize this clinic to send me emails for reminders and informational newsletters.

☐ I authorize this clinic to leave or give information to a spouse, emergency contact or any members of the household.

About You:

Primary Care Physician: _____ Phone: _____

Employment Status: Full Time Part Time Student Retired Unemployed Other

Employer Name: _____ Occupation: _____

Physical Work Duties: _____

Primary Insurance Information:

Insurance Name: _____

Insurance Address: _____

Policy Number: _____ Member ID: _____

Group Number: _____ Phone: _____

Policy Holder's Name: _____ DOB: _____

Relationship to Patient: _____

Address (if different from Patient's): _____

Secondary Insurance Information:

Insurance Name: _____

Insurance Address: _____

Policy Number: _____ Member ID: _____

Group Number: _____ Phone: _____

Policy Holder's Name: _____ DOB: _____

Relationship to Patient: _____

Address (if different from Patient's): _____

General Health History:

Date of Last Physical: _____

Physician: _____ Phone: _____

Please list conditions you have been treated for in the last 5 years: _____

_____

Please list any hospitalizations in the last 5 years: _____

_____

Please list all surgeries or operations: _____

_____

Please list current medications and dosages: _____

_____

List current nutritional supplements (please include all vitamins, minerals and herbs): _____

_____

Please list all car accidents/trauma: _____

_____

Please list all broken bones: _____

_____

Are you a smoker? Yes No Former If Yes, how many packs/day? _____

Do you consume alcohol? Yes No If Yes, how often? _____

How many days per week do you exercise for at least 30 minutes? ____ Type: _____

Please enter any additional information that you feel is relevant to your initial consultation: _____

_____

_____

Primary Problem:

What brought you to our office today?

Are any of your complaints a result of an accident? Auto Worker's Compensation Other None

Please provide details about your symptoms and condition: _____

_____

Have you previously received care/treatment for this condition at another facility? Yes No

If Yes, please fill out the below information - If No, please skip down to Complaint Section..

What is the name(s) of the facility? _____

_____

Please provide details about the care that you received (types of treatment, number of visits, results):

_____

Were diagnostic studies performed (X-Rays, MRI, CT, Ultrasound, EMG) Please describe: None

X-Ray Date: _____ Desc: _____

MRI Date: _____ Desc: _____

CT Date: _____ Desc: _____

Ultrasound Date: _____ Desc: _____

EMG Date: _____ Desc: _____

Other Date: _____ Desc: _____

Complaint 1:

What is the location of your symptom? (Bilateral means both sides)

Side: Left Right Bilateral N/A

Location:

Head	Jaw	Neck	Upper Back	Middle Back	Lower Back	Chest
Shoulder	Arm	Elbow	Forearm	Wrist	Hand	Finger(s)
Gluteal	Head	Buttock	Pelvis	Hip	Thigh	Lower Leg
Ankle	Foot	Toe(s)				

Choose the selection that best describes your symptom(s):

Sharp pain	Dull pain	Throbbing pain	Achiness	Numbness	Tingling
Swelling	Muscle Spasms	Headache	Dizziness	Tightness	Stiffness
Weakness					

How severe are your symptoms?

(0-10 scale is used where 0 is not severe at all and 10 is extremely severe):

0	1	2	3	4	5	6	7	8	9	10

Intensity of pain/tenderness noted: _____

Do your symptoms radiate to other locations? Yes No If yes, location? _____

How frequent are your symptoms?

Occasional (0-25%)	Intermittent (26-50%)	Frequent (51-75%)	Constant (76-100%)

\

Tell us when your symptoms are WORSE?

Morning	Midday	Evening	Night

Tell us when your symptoms are BETTER?

Morning	Midday	Evening	Night

What caused you to first experience symptom(s)? _____

Onset Date: _____

Tell us what makes your symptoms worse?

Driving	Walking	Working	Bending	Sports	Sleeping	Sitting	Standing	Twisting	Lifting

If other, please describe what makes your symptoms worse: _____

_____

Tell us what makes you symptoms better?

Rest	Dry needling	Ice	Heat	Elevation	NSAIDS	Pain Meds	Stretch
Massage	PT	Chiropractic	Acupuncture	Movement			

If other, please describe what makes your symptoms better: _____

_____

Complaint 2:

What is the location of your symptom? (Bilateral means both sides)

Side: Left Right Bilateral N/A

Location:

Head	Jaw	Neck	Upper Back	Middle Back	Lower Back	Chest
Shoulder	Arm	Elbow	Forearm	Wrist	Hand	Finger(s)
Gluteal	Head	Buttock	Pelvis	Hip	Thigh	Lower Leg
Ankle	Foot	Toe(s)				

Choose the selection that best describes your symptom(s):

Sharp pain	Dull pain	Throbbing pain	Achiness	Numbness	Tingling
Swelling	Muscle Spasms	Headache	Dizziness	Tightness	Stiffness
Weakness					

How severe are your symptoms?

(0-10 scale is used where 0 is not severe at all and 10 is extremely severe):

0	1	2	3	4	5	6	7	8	9	10

Intensity of pain/tenderness noted: _____

Do your symptoms radiate to other locations? Yes No If yes, location? _____

How frequent are your symptoms?

Occasional (0-25%)	Intermittent (26-50%)	Frequent (51-75%)	Constant (76-100%)

Tell us when your symptoms are WORSE?

Morning	Midday	Evening	Night

Tell us when your symptoms are BETTER?

Morning	Midday	Evening	Night

What caused you to first experience symptom(s)? _____

Onset Date: _____

Tell us what makes your symptoms worse?

Driving	Walking	Working	Bending	Sports	Sleeping	Sitting	Standing	Twisting	Lifting

If other, please describe what makes your symptoms worse: _____

_____

Tell us what makes you symptoms better?

Rest	Dry needling	Ice	Heat	Elevation	NSAIDS	Pain Meds	Stretch
Massage	PT	Chiropractic	Acupuncture	Movement			

If other, please describe what makes your symptoms better: _____

_____

Complaint 3:

What is the location of your symptom? (Bilateral means both sides)

Side: Left Right Bilateral N/A

Location:

Head	Jaw	Neck	Upper Back	Middle Back	Lower Back	Chest
Shoulder	Arm	Elbow	Forearm	Wrist	Hand	Finger(s)
Gluteal	Head	Buttock	Pelvis	Hip	Thigh	Lower Leg
Ankle	Foot	Toe(s)				

Choose the selection that best describes your symptom(s):

Sharp pain	Dull pain	Throbbing pain	Achiness	Numbness	Tingling
Swelling	Muscle Spasms	Headache	Dizziness	Tightness	Stiffness
Weakness					

How severe are your symptoms?

(0-10 scale is used where 0 is not severe at all and 10 is extremely severe):

0	1	2	3	4	5	6	7	8	9	10

Intensity of pain/tenderness noted: _____

Do your symptoms radiate to other locations? Yes No If yes, location? _____

How frequent are your symptoms?

Occasional (0-25%)	Intermittent (26-50%)	Frequent (51-75%)	Constant (76-100%)

Tell us when your symptoms are WORSE?

Morning	Midday	Evening	Night

Tell us when your symptoms are BETTER?

Morning	Midday	Evening	Night

What caused you to first experience symptom(s)? _____

Onset Date: _____

Tell us what makes your symptoms worse?

Driving	Walking	Working	Bending	Sports	Sleeping	Sitting	Standing	Twisting	Lifting

If other, please describe what makes your symptoms worse: _____

_____

Tell us what makes you symptoms better?

Rest	Dry needling	Ice	Heat	Elevation	NSAIDS	Pain Meds	Stretch
Massage	PT	Chiropractic	Acupuncture	Movement			

If other, please describe what makes your symptoms better: _____

_____

Other Complaint:

If there is any problem that is not listed above that you like your doctor to know about, or may be important, please list below: _____

_____

_____

(If you have more than 3 complaints, please see front desk for additional complaints sheet)

Goals of Care

What would you like to do that you can't due to your condition?

1. _____
2. _____
3. _____

Activities of Daily Living:

Please circle the activities that you difficulty performing:

bending	carrying	climbing	concentrating	dancing	Doing chores
doing computer work	dressing	driving	gardening	lifting	performing sexual activity
playing sports	pushing	reading	performing recreational activity	rolling over	running
shoveling	sitting	sitting to standing	sleeping	standing	walking
watching tv	working				

Family History:

Condition	Family Member
Cancer	
High Blood Pressure	
Heart Attack	
Diabetes	
Stroke	
Osteoarthritis	

HEALTH ISSUES

Please CIRCLE present issues and UNDERLINE issues you have had in the past

Allergic/Immunologic	Cardiovascular	Constitutional Symptoms
Allergic reactions Anaphylaxis history Angioedema history Drug allergies Frequent Injections Hay Fever Hepatitis HIV Positive Positive PPD Seasonal Allergies _____	Chest pain Heart murmur High blood pressure Irregular heartbeat Swelling of legs Use of Oxygen Varicose Veins _____ _____ _____ _____	Chills Fever Poor Appetite Weakness Weight loss/gain _____ _____ _____ _____ _____ _____
Ear/ Nose/ Throat & Mouth	**Endocrine**	**Eyes**
Difficulty hearing Earaches Ear Infection Sinus Problem(s) Sore Throat _____ _____ _____ _____	Diabetes Type 1 Diabetes Type 2 Excessive/Increased thirst Heat/Cold intolerance Hypoglycemia Thyroid Tired/Sluggish Too hot/cold _____	Blurred vision Change in vision Double vision Glasses Pain _____ _____ _____ _____
Gastrointestinal	**Genitourinary**	**GYN**
Abdominal Pain Blood in stool Constipation Diarrhea Gluten Intolerance Indigestion/Heartburn Jaundice Nausea/Vomiting Ulcers _____	Blood in urine Discharge (Penile or Vaginal) Painful urination Urinary frequency Urinary retention _____	Difficulty Sleeping Symptomatic hot flashes Symptomatic vaginal dryness _____
Hematologic/Lymphatic	**Musculoskeletal**	**Neurological**
Anemia Blood clotting problems Easy bruising or bleeding Enlarged lymph nodes Frequent bleeding from gums Swollen glands _____ _____ _____ _____ _____	Head Pain/Symptoms Neck Pain/Symptoms Upper/Mid Back Pain/Symptoms Lower Back Pain/Symptoms Tailbone Pain/Symptoms Shoulder Pain/Symptoms Arm Pain/Symptoms Elbow Pain/Symptoms Hand/Wrist Pain/Symptoms Hip Pain/Symptoms Leg Pain/Symptoms	Dizzy spells Headaches Loss of balance Migraines Numbness/Tingling Tremors Ringing in ear Seizures Slurred Speech Stroke Weakness

	Knee Pain/Symptoms Foot/Ankle Pain/Symptoms Generalized Stiffness Generalized Joint Pain/Symptoms Walking/Balancing Problems Osteoporosis	_____ _____ _____ _____ _____
Psychiatric Depression Memory loss/forgetfulness _____ _____ _____ _____	Respiratory Blood in sputum Frequent cough Shortness of breath Wheezing _____ _____	Skin Boils Change in skin color Lump/Growth on skin Persistent Itch Skin rash _____