Name_____ Today's Date _____

Chief Complaint:_____

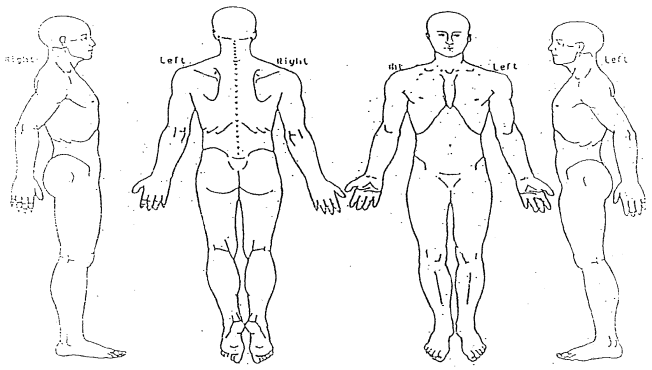
Timing: Worse AM□ or PM□ Context: Better when Hot□ Cold□ Worse When Hot□ Cold□ Damp□

Level of Impairment Due to Symptoms (when Resting): 0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (with Activity): 0 1 2 3 4 5 6 7 8 9 10

Quality: □ Sharp □ Burning
□ Tingling/Pins □ Stabbing
□ Dull □ Shooting
□ Radiating □ Diffuse
□ Stiff/Tight □ Numbness
□ Throbbing □ Ache
□ Localized □ Travels
□ Intermittent □ Constant

Severity: □ Mild
□ Mild/Moderate
□ Moderate
□ Moderate/Severe
□ Severe



Please circle location of your symptom(s).

Better with: □ Rest □ Activity □ Movement □ Bending □ Twisting □ Sitting □ Standing
□ Heat □ Walking □ Ice/Cold □ Other:

Worse with: □ Activity □ Movement □ Bending □ Twisting □ Sitting □ Standing □ Walking

Is this condition worse during certain times of the day?_____

Is this condition interfering with work? _____Sleep? _____Routine? _____Other? _____

Is this condition progressively getting worse?_____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint?

_____

_____

Please answer the following and if your answer is Yes, give brief details:

Did/do you smoke? Y N _____
Did/do you drink alcohol? Y N _____
Did/do you have occupational stress? Y N _____
Physical stress? Y N _____
Emotional/Mental stress? Y N _____
Allergies Y N _____
Sleeping posture? O side O stomach O back

Previous illnesses you've had in your life: _____

_____

Previous injury or trauma (please include any automobile or work-related accident: _____

_____

Have you ever broken any bones? Which? _____

Patient Name_____ **Date** _____

Please check each box that applies. Note the duration and the last time you had this symptom.

Cardiovascular/Vertebrobasilar/Respiratory/Gastrointestinal Systems

- ❑ General swelling
- ❑ Swelling in legs
- ❑ Swelling in face
- ❑ Swelling around eyes
- ❑ Chest pain
- ❑ Pounding heart beat
- ❑ Heart "jumps"
- ❑ Rapid heart beat
- ❑ Blue or purple skin
- ❑ Blue or purple nailbeds
- ❑ Fainting
- ❑ Hypertension
- ❑ Double vision
- ❑ Loss of coordination
- ❑ Irregular muscle movement
- ❑ Ringing in ears
- ❑ Heart attack
- ❑ Cancer
- ❑ Stroke
- ❑ Depression
- ❑ Rheumatic fever
- ❑ Hypoglycemia
- ❑ Polio
- ❑ Irritability
- ❑ Irregular heart beat
- ❑ Hardening of the arteries
- ❑ Areas of muscle weakness
- ❑ Dizziness with nausea
- ❑ Dizziness without nausea
- ❑ Blurred vision
- ❑ Fainting spells
- ❑ Stroke
- ❑ Diabetes
- ❑ Pain over the heart
- ❑ Cold hands and/or feet
- ❑ Areas of numbness
- ❑ Arthritis
- ❑ Previous neck or head injury
- ❑ Loss of memory
- ❑ Inability to form words
- ❑ Periods of blindness in one eye
- ❑ Blood vessel disease (phlebitis, etc.)
- ❑ Asthma
- ❑ Fatigue
- ❑ Anemia
- ❑ Multiple sclerosis
- ❑ Tuberculosis
- ❑ Nervousness
- ❑ Shortness of breath
- ❑ Can't breathe while lying down
- ❑ Can't sleep while lying down
- ❑ Dry cough
- ❑ Productive cough
- ❑ Coughing up blood
- ❑ Poor appetite
- ❑ Constant nibbling
- ❑ Difficulty in swallowing
- ❑ Indigestion
- ❑ Nausea and vomiting
- ❑ Jaundice
- ❑ Abdominal pain
- ❑ Change in bowel habits
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Stomach upset
- ❑ Tension
- ❑ Weight loss
- ❑ Epilepsy
- ❑ Parkinson's disease
- ❑ HIV/AIDS
- ❑ Sleeping problems

Musculoskeletal System

- ❑ Unusually frequent headache
- ❑ Unusually severe headache
- ❑ Head feels heavy
- ❑ Vertigo
- ❑ Light-headedness
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Loss of balance
- ❑ Dizziness
- ❑ Pain in neck
- ❑ Neck pain with movement
- ❑ Swelling in neck
- ❑ Stiff neck
- ❑ Pinched nerve in neck
- ❑ Neck feels out of place
- ❑ Grinding sound in neck
- ❑ Popping sound in neck
- ❑ Limited neck movement
- ❑ Spasms in neck
- ❑ Pain in shoulders R L
- ❑ Pain across shoulders
- ❑ Tension in shoulders R L
- ❑ Muscle spasms in shoulders R L
- ❑ Can't raise arm above shoulder level
- ❑ Can't raise arm over head R L
- ❑ Pain in upper arm R L
- ❑ Pain in forearm R L
- ❑ Pain in hands R L
- ❑ Pain in fingers R L
- ❑ Pins & needles in arms R L
- ❑ Pins & needles in fingers R L
- ❑ Fingers go to sleep R L
- ❑ Hands cold R L
- ❑ Swollen joints in fingers R L
- ❑ Sore joints in fingers R L
- ❑ Loss of grip strength R L
- ❑ Mid-back pain
- ❑ Pain between shoulder blades
- ❑ Sharp stabbing pain in mid back
- ❑ Dull ache in mid back
- ❑ Pain from front to back
- ❑ Pain over kidney area
- ❑ Muscle spasms in mid back
- ❑ Low back pain
- ❑ Low back feels out of place
- ❑ Muscle spasms in low back
- ❑ Pain in buttocks
- ❑ Pain down leg R L
- ❑ Knee pain R L
- ❑ Leg cramps R L
- ❑ Pins & needles in legs R L
- ❑ Numbness in leg R L
- ❑ Cold feet R L
- ❑ Swollen ankles R L
- ❑ Swollen feet R L

Skin/Hair/Nails/Eyes/Ears/Nose/Nasopharynx/Sinuses/Mouth and Throat/Genitourinary/Venereal Disease/Other

- ❑ Eczema
- ❑ Itchy skin
- ❑ Dry scalp
- ❑ Oily scalp
- ❑ Rough, scaly skin
- ❑ Oily skin
- ❑ Dry skin
- ❑ Psoriasis
- ❑ Yellow skin
- ❑ Bruise easily
- ❑ Paper thin nails
- ❑ Pale skin
- ❑ Nail biting
- ❑ Baldness
- ❑ Blurring of vision
- ❑ Double vision
- ❑ Eyes fatigue easily
- ❑ Excessive tearing
- ❑ Lack of tearing
- ❑ Light bothers eyes
- ❑ Excessive itching
- ❑ Pain in eyeball
- ❑ Loss of hearing
- ❑ Pain in ears
- ❑ Discharge from ears
- ❑ Vertigo
- ❑ Ringing in ears
- ❑ Unusual nasal discharge
- ❑ Nose bleeds
- ❑ Pressure over eyes
- ❑ Pressure under eyes
- ❑ Obstruction of nose
- ❑ Frequent colds
- ❑ Sinusitis
- ❑ Nasal allergies
- ❑ Loss of sense of smell
- ❑ Any trauma to nose
- ❑ Pain of mouth
- ❑ Pain of throat
- ❑ Bleeding gums
- ❑ Cavities
- ❑ Loss of sense of taste
- ❑ Crave sweets
- ❑ Crave salt
- ❑ Abscessed teeth
- ❑ Dentures
- ❑ Difficulty swallowing
- ❑ Changes in voice
- ❑ Urination is frequent
- ❑ Urination is normal
- ❑ Urination is infrequent
- ❑ The amount of urination is high
- ❑ The amount of urination is normal
- ❑ The amount of urination is low
- ❑ Need to get up at night to urinate
- ❑ Abnormal intense desire to urinate
- ❑ Difficulty starting urination
- ❑ Decreased output
- ❑ Pain upon urination
- ❑ Dribbling
- ❑ Blood in urine
- ❑ Cloudy urine
- ❑ Lack of bladder control
- ❑ Abdominal pain
- ❑ Syphilis
- ❑ Gonorrhea

Current Medications **Reason for taking**

_____ _____

_____ _____

_____ _____

Surgeries:

Date Type of Surgery

_____ _____

_____ _____

_____ _____

Females:

Pregnancies/Date of Delivery Outcome

_____ _____

_____ _____

_____ _____

What was the date of the beginning of your last menstrual period? _____Do you have painful periods? ___ Yes ___ No
Do you have premenstrual symptoms? ___ Yes ___ No Do you have vaginal discharge? ___ Yes ___ No
Do you have spotting? ___ Yes ___ No Do you have irregular periods? ___ Yes ___ No
Do you have menstrual cramps? ___ Yes ___ No Do you have lumps in your breasts? ___ Yes ___ No

Family Health History:

Associated health problems of relatives: _____
_____

Deaths in immediate family:

Cause of parents or siblings death Age at death

_____ _____

_____ _____

_____ _____

Children's Names and Ages:_____

Social and Occupational History:

Job description: _____

Work schedule: _____

Recreational activities: _____

Lifestyle (hobbies, level of exercise, diet):_____

PATIENTS NEED TO BE AWARE:

- Services that are not covered by insurance and must be paid in full at the time of rendering are Avatar testing, Bio-Ray treatments, IV chelation therapy, supplements, and consults by the doctor that are not nutritional or spinal in nature.
- We ask our patients to give us 24 hours notice of an appointment cancellation. With discretion, we reserve the right to charge for the time allotted for these appointments if proper notice was not given.

I have read the information on these pages and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of to provide me with care, in accordance the doctor's licensures and with this state's statutes.

Patient or Parent/Guardian Signature _____ Date _____