

Patient Name _____ Patient ID# _____

If you have ever had a listed symptom in the past, please check that symptom in the *Past Column*. If you are presently troubled by a particular symptom, check that symptom in the *Present Column*. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

- | Past | Present | Condition |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain (R___) (L___) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Arm or Elbow (R___) (L___) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain (R___) (L___) |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain (R___) (L___) |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in the Upper Leg or Hip(R___)(L___) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in the Lower Leg or Knee(R___)(L___) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in the Ankle or Foot(R___)(L___) |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling, Stiffness of Joint(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular Incoordination |
| <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus (Ear Noises) |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid Heart Beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight |
| | | <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis |
| <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Menstrual Flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Profuse Menstrual Flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast <input type="checkbox"/> Soreness <input type="checkbox"/> Lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis |
| <input type="checkbox"/> | <input type="checkbox"/> | PMS |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation/irregular bowel habits |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in Swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/Indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash |

- | Past | Present | Condition |
|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack (date)_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date)_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer, Explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumor, Explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema(chronic lung issues) |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver/Gallbladder problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders (by condition) |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable Colon |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

If a family member has had any of the following, please mark the appropriate box:

- | | |
|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Back Problems |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Chronic Headaches |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Other _____ | |

Present Weight _____ pounds Height _____ feet _____ inches

Yes No
 Do you have a permanent disability rating? Location _____
 Date rating received ____/____/____
 Rating Percentage _____%

Please check any of the following that apply to you

- | Past | Present | Condition | Past | Present | Condition |
|--------------------------|--------------------------|--|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # births _____ | <input type="checkbox"/> | <input type="checkbox"/> | Tobacco |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills, type _____ | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol |
| <input type="checkbox"/> | <input type="checkbox"/> | Medications (list if not listed elsewhere) _____ | <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Dependence |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Coffee/Tea/Caffinated drinks: _____ |
| | | | | | cups/cans perday _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospitalizations/Surgical Procedures (list if not described elsewhere) _____ | | | |

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages in the future.

Patient Signature: _____ Date: _____