PLEASE FILL OUT THE FOLLOWING SECTIONS

REASON FOR TODAY'S VISIT

Primary Concern: _____

Location of Problem: _____

Date of Onset (If Known): _____

Can You Describe Your Symptoms?: _____

_____

_____

Onset: Gradual Sudden **Duration:** _____ D W M Y

Pain Assessment **Severity** None 1 2 3 4 5 6 7 8 9 10 (Worst Pain Ever)

Pain Quality Sharp Shooting Dull Aching Throbbing Burning Tingling

Timing of Pain AM PM Constant Intermittent

[] During Activity [] After Activity [] At Rest

Does Anything Make It Feel Better?: _____

Does Anything Make It Feel Worse?: _____

Have You Done Anything to Treat this Problem? (Describe): _____

_____

_____

Height: Weight: Shoe Size: Occupation:

Do You Have or Have You Ever Had:

YES	NO	(CIRCLE those that apply & write in others)
		Eye, Ear, Nose, Throat: (glaucoma, lens implants, dentures, loose teeth, dental caps or bridges, hearing aids, glasses/contacts, artificial eye)
		Heart Problems: (chest pain, angina, heart attack, congestive heart failure, irregular heart beats, pacemaker)
		Vascular Problems: (high blood pressure, blood clots)
		Lung Problems: (asthma, emphysema, tuberculosis, coughing, coughing blood, abnormal chest x-ray, sleep apnea)
		Gastrointestinal Problems: (hepatitis, cirrhosis, ulcers, hiatal hernia, intestinal bleeding)
		Genitourinary Problems: (kidney disease/failure, dialysis, prostate problems, incontinence, OB/GYN sexually transmitted disease, infections)
		Is There Any Possibility You Could Be Pregnant? **Birth Control Y N** **LMP**_____
		Musculoskeletal Problems: (back problems, broken bones neck/back/face, limited range of motion, arthritis, TMJ)
		Skin Problems: (rash, hives, bruise easily, open sores)
		Neurological Problems: (stroke, seizures, paralysis, numbness, weakness, confusion, migranes)
		Mental Illness: (anxiety, depression, bipolar disorder)
		Diabetes: Diet Oral Med Insulin
		Other Endocrine Problems: (thyroid)
		Anemia / Unusual Bleeding:
		Cancer: Active / Remission
		A Bad Reaction to Anesthesia? Describe:

Hospitalizations, Procedures, Illnesses, Surgeries (Last 10 Yrs):

_____

_____

_____

_____

_____

Current Medications: (Include any Over-the Counter or Herbal Meds):

_____

_____

_____

_____

_____

_____

Drug Allergies: _____

_____

_____

Do You Use:	Yes	No	How Often / Last Use
Tobacco			
Alcohol			
Illicit Drugs			

PATIENT/RESPONSIBLE PERSON SIGNATURE

PHYSICIAN ONLY

[] ROS Reviewed [] History Reviewed

DOB _____ **PATIENT NAME** _____ **INITIAL VISIT** _____