

INITIAL INTAKE EXAMINATION/HEALTH HISTORY

Name: _____ DOB: _____ Age: _____ Date of Exam: _____

(Office use) Vitals: Ht: _____ Wt.: _____ BP: _____ P: _____ SPo2: _____

How did you hear about us? _____

What is location of your pain? _____ Pain Level (0-10) _____

When did it occur? _____

Was there a method of injury? _____

What, if anything has made the problem worse? Driving Walking Working Bending Sports Sleeping

What, if anything, has made the problem better? Rest Ice Heat Elevation NSAIDS Pain Meds

History of Present Injury/Illness:

- | | | | | |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Bowel/Bladder Changes | |

Ever been diagnosed with any of the following:

- | | | | | |
|---|---|------------------------------------|---|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraines | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pinched nerve | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Herniated disc | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding Disorders | |

Are you currently under drug and/or medical care? Yes No who is your primary care doctor? _____
Are you under the care of a specialist? Yes No

Please all medications: (Be sure to include dosage and frequency) _____

Supplements (vitamins/herbs/minerals): _____

Allergies: _____

Surgeries and/or hospitalizations (type & date): _____

Approximate Date of last Flu vaccine: _____ **WOMEN ONLY:** Date of LMP: _____ *any possibility of pregnancy: YES or No*

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

- | | |
|--|--|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ |
| | <input type="checkbox"/> Other _____ |

Intake of following: Cigarettes _____ packs/day Alcohol _____ drinks/week Caffeine _____ cups/day

Exercise frequency: Never Daily Weekly Walks Runs Swims

Occupation: _____ Does work mostly involve: Sitting Standing Light Labor Heavy Labor

Reviewed with patient by: _____