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Name:_____ Age:_____Date:_____

1. **What is your chief complaint? (Exact location of pain, if any)**

_____

2. **How long have you had it?**

_____

3. **What caused it?**

_____

4. **Sudden or gradual onset? Is it getting better or worse?**

_____

5. **What have <u>you</u> done for it?**

_____

6. **Have you had treatment for this complaint? If so, what?**

_____

7. **Are you going to another doctor for treatment of any kind? If so, what for?**

_____

8. **What medicine/medicines, if any, are you now taking?**

_____

9. **Do you have any drug allergies? Other allergies?**

_____

10. **Do you smoke? _____ Packs per day? _____**
11. **Do you drink alcoholic beverages? _____ How often? _____**
12. **List operations (including tonsils) and approximate date:**

_____

13. List serious illnesses you have had and approximate date.

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14. Accidents – List approximate date and extent of injury.

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15. List any traumas. (Whiplash, falls, strain/sprains, fractures, etc.)

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16. Have you had any x-rays and laboratory work done in the last 10 years?
If so, what were you told about the results?

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17. Are you suffering from any other complaints, other than what you described on the other side of the paper?

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18. Type of employment?

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19. Family History:

Diabetes Mellitus?	TB?	Blood Pressure?
Heart Disease?	Stroke?	Cancer?
Ulcers?	Other?	

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20. Gyn History

Pregnancies?	First day of last menstrual period?
Children living?	
Normal Menses?	Last PAP and results?
Irregular Periods?	Breast Lumps?

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21. Last complete physical exam:

When?
Who?
Any significant findings?

Signature: _____

Please check if appropriate:

GENERAL

___ Poor Appetite
___ Poor Sleeping
___ Chills
___ Weight Gain
___ Tremors
___ Poor Balance
___ Weight Loss
___ Sudden energy drop (what time of day?)
___ Fatigue
___ Cravings
___ Change in Appetite

SKIN AND HAIR

___ Rashes
___ Recent moles or change in appearance
___ Loss of Hair
___ Change in hair or skin texture
___ Hives

Any other hair or skin problems?

HEAD, EYES, NOSE, AND THROAT

___ Dizziness
___ Eye Pain
___ Ringing in the ears
___ Nose Bleeds
___ Facial Pain
___ Concussions
___ Cataracts
___ Poor hearing
___ Recurrent Sore Throats
___ Migraines
___ Blurry Vision
___ Sinus Problems
___ Grinding Teeth
___ Sore on lips or tongue

Headaches (where and when?):

Any other head or neck problems:

CARDIOVASCULAR

___ High Blood Pressure
___ Fainting
___ Phlebitis
___ Chest Pain
___ Cold Hands or Feet
___ Difficulty in Breathing
___ Irregular Heartbeat
___ Swelling of Feet

Any other Heart of Blood Vessel Problems?

RESPIRATORY

___ Chronic Cough
___ Bronchitis
___ Production of Phlegm, what color?
___ Coughing Blood
___ Pneumonia
___ Asthma
___ Pain with a Deep Breath

Any other Lung Problems?

GASTROINTESTINAL

___ Nausea
___ Constipation
___ Blood in Stools
___ Hemorrhoids
___ Vomiting
___ Gas
___ Indigestion
___ Chronic Laxative Use
___ Diarrhea
___ Black Stools
___ Rectal Pain

Any other Problems with your Stomach or intestines?

(over)

GENITO-URINARY

___ Pain on Urination
___ Urgency to Urinate
___ Decrease in Flow
___ Frequent Urination
___ Unable to Hold Urine
___ Blood in Urine
___ Kidney Stones

Do you wake up to urinate:
Any other problems with your genital or urinary system?

MUSCULOSKELETAL

___ Neck Pain
___ Back Pain
___ Hand/Wrist Pains
___ Muscle Pains
___ Muscle Weakness
___ Shoulder Pain
___ Knee Pain
___ Foot/Ankle Pains
___ Hip Pain

Any other joint or bone problems?

NEUROPSYCHOLOGICAL

___ Seizures
___ Lack of Coordination
___ Depression
___ Loss of Balance
___ Poor Memory
___ Anxiety
___ Areas of Numbness
___ Concussions
___ Easily Susceptible to stress

Have you ever been treated for emotional problems?
Have you ever considered or attempted suicide?
Any other neurological or psychological problems?

COMMENTS

Please tell us of any other problem you would like to discuss:

Signature: _____

SUBSTANCE SURVEY FORM

Name_____ Date_____

Please list any prescription medications you are currently taking or have taken in the last year:

Medications	Diagnosis

Please list any over-the-counter medications you are currently taking or have taken in the last year:

Product	Symptom	Quantity & Frequency

Please list any vitamins, supplements, herbs, or homeopathic medicines you are currently taking or have taken in the last year. (Use other side if needed.)

Product	Amount Taken Daily	How Long Taken

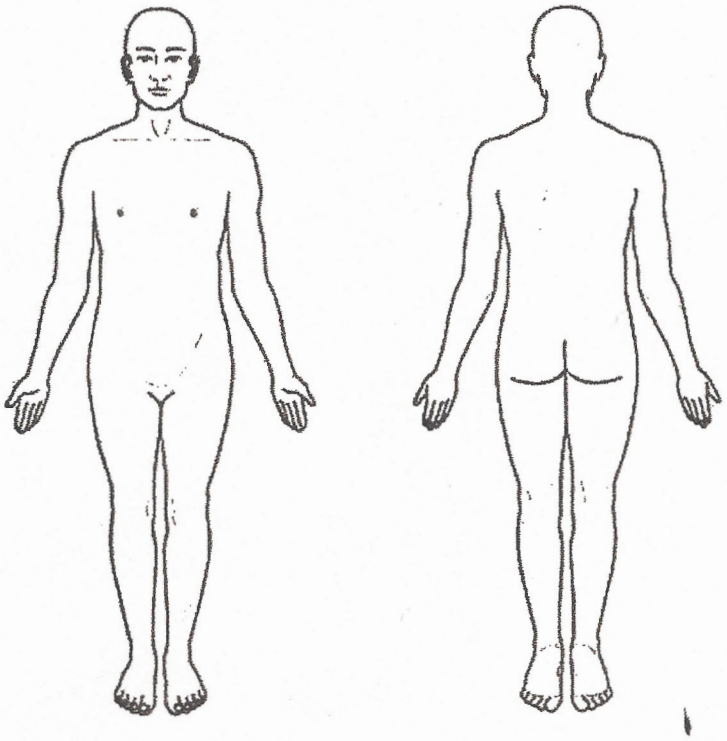
Check the following items that apply to you and indicate the amount used:

- ☐ Coffee_____
- ☐ Tea_____
- ☐ Soft Drinks_____
- ☐ Artificial Sweetener_____
- ☐ Antacids_____
- ☐ Laxatives _____
- ☐ Candy_____
- ☐ Ice Cream_____
- ☐ Alcohol _____
- ☐ Cigarettes_____
- ☐ Other Tobacco Products _____

How many desserts do you have in an average week? _____

Using the symbols below, please draw in the location of your symptoms on the diagram.

XXX= Burning OOO= Numbness ////= Stabbing ^^^= Aching *= Pins & Needles**



Please mark the scales below to indicate the intensity level of your symptoms/pain. "None" on the left side of the scale indicates No Pain, and "10" on the right side of the scale indicates Severe Pain that might cause one to faint.

What is your worst pain?	None	1	2	3	4	5	6	7	8	9	10
What is your least pain?	None	1	2	3	4	5	6	7	8	9	10
What is your pain today?	None	1	2	3	4	5	6	7	8	9	10

INCREASE OR DECREASE OF SYMPTOMS/PAIN

	WORSE	BETTER	COMMENTS
Bending			
Bowel Movement			
Coughing/ Sneezing			
Lifting			
Sitting to Standing			
Lying Down			
Standing			
Walking			
Sitting			
Climbing Stairs			
Other:			