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:

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

_____

_____

Ever been diagnosed with any of the following:

❑ Hypertension	❑ Heart Disease	❑ Migraines	❑ Liver Disease	❑Rheumatoid Arthritis
❑ Diabetes	❑ Pinched nerve	❑ Cancer	❑ Kidney Disease	❑ Fibromyalgia
❑ High cholesterol	❑ Herniated disc	❑ Ulcers	❑ Osteoporosis	❑ Thyroid problems
❑ Pacemaker	❑ Stroke	❑ Arthritis	❑ 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**)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ 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: _____