☐ 8901 Activity Road, San Diego, CA 92126
Tel. (844) 627-4763 Fax: (760) 635-7801
☐ 499 N. El Camino Real Ste C-200 Encinitas, CA 92024
Tel. (760) 635-7800 Fax: (760) 635-7801

Patient:	DOB:	ID#	Date:

What problem (s) brought you to see us? _____

_____

_____

When did the problem(s) start? _____

The problem(s) developed: ☐ Suddenly ☐ Built up over several days ☐ Gradually worse over a long time

What kind of pain are you experiencing?

Dull Ache Burning Sharp/Stabbing Pins & Needles Throbbing

Where is the pain?

Foot: Right Left _____

Leg: Right Left _____

Knee: Right Left _____

Hip: Right Left _____

Shoulder: Right Left _____

Hand/Fingers: Right Left _____

Arm: Right Left _____

Head: _____

Neck: _____

Back: _____

Other: _____

_____

On a scale of 1 to 10, with 1 being light pain and 10 being very severe, how severe is your pain most of the time and how frequent is your pain?

Intensity (0-10) _____ **Frequency (0-100%)**_____**%**

0 1 2 3 4 5 6 7 8 9 10

Numerical Scale

Factors:

Increase Pain: ☐ Sit ☐ Stand ☐ Walk ☐ Climb ☐ Bend ☐ Squat ☐ Lay Down ☐ Touch ☐ Up Stairs ☐ Down Stairs ☐ Movement

Decrease Pain: ☐ Sit ☐ Stand ☐ Walk ☐ Climb ☐ Bend ☐ Squat ☐ Lay Down ☐ Touch ☐ Up Stairs ☐ Down Stairs ☐ Movement

What have you done to manage this pain up to this point?

☐ 5471 Kearny Villa Rd Ste 200 San Diego, CA 92024
Tel. (858) 571-0606 Fax: (858) 571-1933
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Tel. (760) 635-7800 Fax: (760) 635-7801

Patient:	DOB:	ID#	Date:

Past Medical History

☐ Heart Attack ☐ Lung Disease ☐ Cancer _____ ☐ Mental Illness ☐ Ulcer
☐ Angina ☐ Diabetes ☐ Enlarged Prostate ☐ Compression Fractures ☐ Diverticulosis
☐ Hypertension ☐ Arrhythmia ☐ Fainting ☐ Bulging Discs ☐ Diverticulitis
☐ Kidney Disease ☐ Liver Disease ☐ Anemia ☐ Gout ☐ Other _____
☐ Stroke ☐ HIV ☐ Asthma ☐ COPD ☐ Other _____

Allergies:

MEDICATIONS (Prescription and over the counter)		**HOSPITALIZATION AND SURGERY:** Surgery and date
Name and strength	#Doses / day	

FAMILY HISTORY: (mother, father, grandparents, brothers, sisters, children)

	Condition	**Who?**		**Condition**	**Who?**
	Heart Disease			Diabetes	
	Hypertension			Epilepsy	
	Stroke			Bleeding Disorders	
	Cancer			Kidney Disease	

Special care or issues that might affect your treatment? ☐ NO ☐ YES (describe)

Procedure	Part of body	Date(s)	Place Performed
X-rays			
C.T./MRI			
Ultrasound			
Nerve Conduction			
Other			

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Patient:	DOB:	ID#	Date:

REVIEW OF SYSTEMS:

GENERAL
☐ Tire easily
☐ Recent weight gain
☐ Recent weight loss
☐ Night Sweats

ENT
☐ Blurred vision
☐ Cataracts
☐ Hearing loss
☐ Frequent nosebleeds
☐ Ringing in the ears

HEM/ENDOCRINE
☐ Excessive thirst
☐ Dry mouth
☐ Anemia
☐ HIV
☐ Bruise easily
☐ Blood clots

RESPIRATORY
☐ Shortness of breath;
☐ At night ☐ Laying flat ☐ With walking
☐ Wheezing
☐ Sputum
☐ Cough

CARDIOVASCULAR
☐ Chest pain/tightness: ☐ Exertional ☐ Non-Exertional
☐ Edema/Swelling of legs

MENTAL HEALTH
☐ Anxious
☐ Depressed
☐ Difficulty sleeping

GI/GU
☐ Abdominal pain
☐ Ulcers
☐ Heartburn
☐ Constipation
☐ Diarrhea
☐ Trouble swallowing
☐ Nausea or vomiting
☐ Urinary Frequency
☐ Kidney disease
☐ Incontinence of the bowel or bladder

MUSCULOSKELETAL
☐ Joints are stiff
☐ Joints hurt (which joints?)
☐ Joints are swollen (which joints?)
☐ Muscles aching
☐ Muscle weakness
☐ Gout

SKIN DISORDER
☐ Skin disorder

NEUROLOGICAL
☐ Weakness of arms, legs
☐ Numbness and tingling of arms, legs
☐ Dizziness
☐ Headaches
☐ Seizures
☐ Fainting
☐ Tremors

Employment Status: ☐ Retired ☐ Full Time ☐ Part Time ☐ Homemaker ☐ Student ☐ Unemployed

Marital Status: ☐ Single ☐ Married ☐ Widowed

Habits: ☐ Tobacco_____packs/day or Stopped _____
☐ Alcohol Type/Amount: _____

HT: _____ WT: _____ BP: _____/_____ PULSE: _____ RESP: _____ 02SAT: _____ TEMP: _____