



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

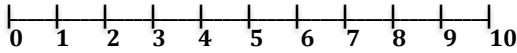
Head: \_\_\_\_\_

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%) \_\_\_\_\_ %

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?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Patient:	DOB:	ID#	Date:
----------	------	-----	-------

### Past Medical History

<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Angina	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Enlarged Prostate	<input type="checkbox"/> Compression Fractures	<input type="checkbox"/> Diverticulosis
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Fainting	<input type="checkbox"/> Bulging Discs	<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Anemia	<input type="checkbox"/> Gout	<input type="checkbox"/> Other _____
<input type="checkbox"/> Stroke	<input type="checkbox"/> HIV	<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD	<input type="checkbox"/> 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? <input type="checkbox"/> NO <input type="checkbox"/> YES (describe)			

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



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: \_\_\_\_\_ O2SAT: \_\_\_\_\_ TEMP: \_\_\_\_\_