patient intake: ALL complaint

PATIENT NAME:_____DATE:_____
Address:_____City:_____Zip:_____
Cell phone:_____Home phone:_____
Social Security #:_____Age:____Birthdate:___/___/____Sex: M F

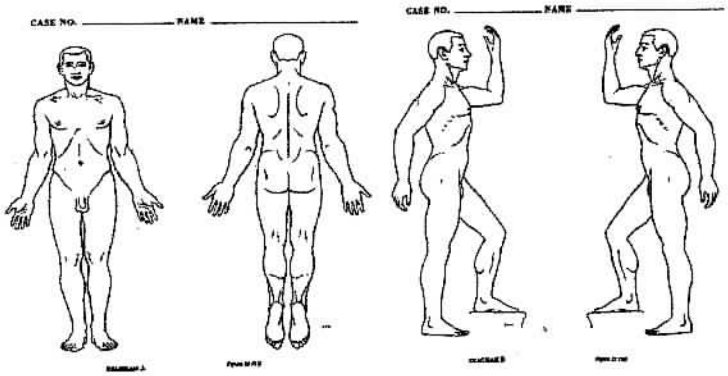
Please check all answers and fill in the blanks where appropriate. Describe your Present Complaint. This information is necessary to assist your health care provider understand your health condition.

Date problem began: ___/___/____Describe your problem and how it began:

_____

_____

_____



mark an X where the problem is :

Rate how severe your pain is (circle corresponding number) 0=none 10=most severe
0 1 2 3 4 5 6 7 8 9 10

How often are your symptoms present? (Circle corresponding)
Constantly Frequently Occasionally Intermittent

Describe your current pain/symptoms:
Sharp/stabbing Throbbing Achy Dull Soreness Weakness Numbness Shooting Burning Tingling Other

Since it began, is your problem:
Improving Getting Worse No Change

What makes the problem better?
Walking Lying Down Standing Sitting Movements Exercise Inactivity/rest Other

What makes the problem worse:
Walking Lying Down Standing Sitting Movements Exercise Inactivity/rest Other

Can you perform your daily home activities? *Yes Yes with help Not at all*

Describe your job requirements: *Heavy Labor Light labor Mainly sitting Mainly stand*

Can you perform your work activities? *Yes, all activities Only some Not at all*

Describe your stress level: *High Moderate Mild None*

What treatment have you had for this condition in the past?
Surgery medications injections physical therapy chiropractic adjustments

_____

_____

What tests have you had for this condition: *X-rays MRI Scans Other:*_____
*Date taken:*_____

I certify that the above information AND the information on the past history form is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future.
*Patient's signature:*_____*Date:*_____

PATIENT NAME:_____DATE:_____

If you have ever had a listed symptom in the Past, please check that symptom in the Past Column. If you are presently troubled by a particular symptom, check that symptom in the Now Column. KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THRAPY YOU RECEIVE.

PAST	NOW	CONDITION	PAST	NOW	CONDITION
		neck pain			depression
		shoulder pain R or L			aortic aneurysm
		upper arm/elbow pain R or L			high blood pressure
		hand pain R or L			angina
		wrist pain R or L			heart attack date:_____
		upper back pain			stroke date:_____
		lower back pain			asthma
		upper leg or hip pain R or L			cancer date:_____ type:_____
		lower leg /knee pain R or L			tumor type:_____
		ankle or foot pain R or L			prostate problems
		swelling stiffness of joints			blood disorder
		visual disturbances			emphysema (chronic lung)
		convulsions			arthritis
		dizziness or vertigo			rheumatoid arthritis
		headache			diabetes
		jaw pain R or L			epilepsy
		muscular incoordination			ulcer
		tinnitus or ringing in ears			liver/gallbladder problems
		rapid heart beat			kidney stones

PAST	NOW	CONDITION	PAST	NOW	CONDITION
		chest pains			hepatitis type:_____
		loss of appetite			bladder infection
		anorexia			kidney disorders type:_____
		abnormal weight gain / loss			colitis
		dermatitis/eczema/rash			irritable colon
		chronic cough			HIV/AIDS
		chronic sinusitis			hospitalizations / Surgeries:
		general fatigue			_____
		irregular menstrual flow			_____
		breast soreness or lumps			
		endometriosis or PMS			Other:_____
		loss of bladder control			HAS FAMILY MEMBER HAD:
		painful urination			lung problems
		frequent urination			epilepsy
		abdominal pain			lupus
		constipation/irregular bowel habits			cancer date:_____ type:_____
		difficulty in swallowing			chronic back problems
		heartburn or indigestion			chronic headaches
		pregnancy #births:_____			high blood pressure
		birth control pills			diabetes
		medications type:_____			heart problems
		_____			rheumatoid arthritis
		drug or alcohol dependence			