

Name _____ Today's Date _____

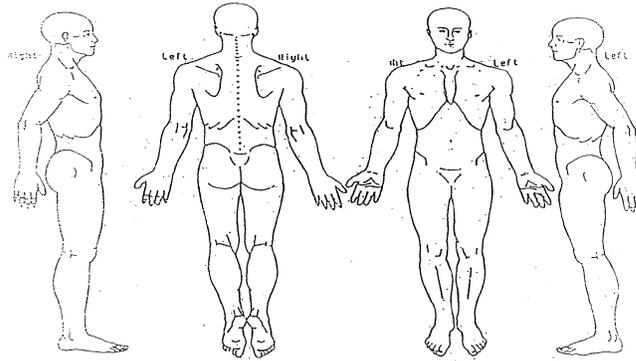
Chief Complaint: _____

Timing: Worse AM or PM Context: Better when Hot Cold Worse When Hot Cold Damp

Level of Impairment Due to Symptoms (when Resting): 0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (with Activity): 0 1 2 3 4 5 6 7 8 9 10

- | | | |
|-----------|--|-----------------------------------|
| Quality: | <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning |
| | <input type="checkbox"/> Tingling/Pins | <input type="checkbox"/> Stabbing |
| | <input type="checkbox"/> Dull | <input type="checkbox"/> Shooting |
| | <input type="checkbox"/> Radiating | <input type="checkbox"/> Diffuse |
| | <input type="checkbox"/> Stiff/Tight | <input type="checkbox"/> Numbness |
| | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Ache |
| | <input type="checkbox"/> Localized | <input type="checkbox"/> Travels |
| | <input type="checkbox"/> Intermittent | <input type="checkbox"/> Constant |
| Severity: | <input type="checkbox"/> Mild | |
| | <input type="checkbox"/> Mild/Moderate | |
| | <input type="checkbox"/> Moderate | |
| | <input type="checkbox"/> Moderate/Severe | |
| | <input type="checkbox"/> Severe | |



Please circle location of your symptom(s).

Better with: Rest Activity Movement Bending Twisting Sitting Standing
 Heat Walking Ice/Cold Other:

Worse with: Activity Movement Bending Twisting Sitting Standing Walking

Is this condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition progressively getting worse? _____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint?

Please answer the following and if your answer is Yes, give brief details:

- | | | | |
|--------------------------------------|--------|-----------|--------|
| Did/do you smoke? | Y | N | _____ |
| Did/do you drink alcohol? | Y | N | _____ |
| Did/do you have occupational stress? | Y | N | _____ |
| Physical stress? | Y | N | _____ |
| Emotional/Mental stress? | Y | N | _____ |
| Allergies | Y | N | _____ |
| Sleeping posture? | O side | O stomach | O back |

Previous illnesses you've had in your life: _____

Previous injury or trauma (please include any automobile or work-related accident: _____

Have you ever broken any bones? Which? _____

Patient Name _____

Date _____

Please check each box that applies. Note the duration and the last time you had this symptom.

Cardiovascular/Vertebrobasilar/Respiratory/Gastrointestinal Systems

<input type="checkbox"/> General swelling <input type="checkbox"/> Swelling in legs <input type="checkbox"/> Swelling in face <input type="checkbox"/> Swelling around eyes <input type="checkbox"/> Chest pain <input type="checkbox"/> Pounding heart beat <input type="checkbox"/> Heart "jumps" <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Blue or purple skin <input type="checkbox"/> Blue or purple nailbeds <input type="checkbox"/> Fainting <input type="checkbox"/> Hypertension <input type="checkbox"/> Double vision <input type="checkbox"/> Loss of coordination <input type="checkbox"/> Irregular muscle movement <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Heart attack <input type="checkbox"/> Cancer <input type="checkbox"/> Stroke <input type="checkbox"/> Depression <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Polio <input type="checkbox"/> Irritability	<input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Hardening of the arteries <input type="checkbox"/> Areas of muscle weakness <input type="checkbox"/> Dizziness with nausea <input type="checkbox"/> Dizziness without nausea <input type="checkbox"/> Blurred vision <input type="checkbox"/> Fainting spells <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes <input type="checkbox"/> Pain over the heart <input type="checkbox"/> Cold hands and/or feet <input type="checkbox"/> Areas of numbness <input type="checkbox"/> Arthritis <input type="checkbox"/> Previous neck or head injury <input type="checkbox"/> Loss of memory <input type="checkbox"/> Inability to form words <input type="checkbox"/> Periods of blindness in one eye <input type="checkbox"/> Blood vessel disease (phlebitis, etc.) <input type="checkbox"/> Asthma <input type="checkbox"/> Fatigue <input type="checkbox"/> Anemia <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Nervousness	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Can't breathe while lying down <input type="checkbox"/> Can't sleep while lying down <input type="checkbox"/> Dry cough <input type="checkbox"/> Productive cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Poor appetite <input type="checkbox"/> Constant nibbling <input type="checkbox"/> Difficulty in swallowing <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea and vomiting <input type="checkbox"/> Jaundice <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Stomach upset <input type="checkbox"/> Tension <input type="checkbox"/> Weight loss <input type="checkbox"/> Epilepsy <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Sleeping problems
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Musculoskeletal System

<input type="checkbox"/> Unusually frequent headache <input type="checkbox"/> Unusually severe headache <input type="checkbox"/> Head feels heavy <input type="checkbox"/> Vertigo <input type="checkbox"/> Light-headedness <input type="checkbox"/> Loss of smell <input type="checkbox"/> Loss of taste <input type="checkbox"/> Loss of balance <input type="checkbox"/> Dizziness <input type="checkbox"/> Pain in neck <input type="checkbox"/> Neck pain with movement <input type="checkbox"/> Swelling in neck <input type="checkbox"/> Stiff neck <input type="checkbox"/> Pinched nerve in neck <input type="checkbox"/> Neck feels out of place <input type="checkbox"/> Grinding sound in neck <input type="checkbox"/> Popping sound in neck <input type="checkbox"/> Limited neck movement <input type="checkbox"/> Spasms in neck	<input type="checkbox"/> Pain in shoulders R L <input type="checkbox"/> Pain across shoulders <input type="checkbox"/> Tension in shoulders R L <input type="checkbox"/> Muscle spasms in shoulders R L <input type="checkbox"/> Can't raise arm above shoulder level <input type="checkbox"/> Can't raise arm over head R L <input type="checkbox"/> Pain in upper arm R L <input type="checkbox"/> Pain in forearm R L <input type="checkbox"/> Pain in hands R L <input type="checkbox"/> Pain in fingers R L <input type="checkbox"/> Pins & needles in arms R L <input type="checkbox"/> Pins & needles in fingers R L <input type="checkbox"/> Fingers go to sleep R L <input type="checkbox"/> Hands cold R L <input type="checkbox"/> Swollen joints in fingers R L <input type="checkbox"/> Sore joints in fingers R L <input type="checkbox"/> Loss of grip strength R L <input type="checkbox"/> Mid-back pain	<input type="checkbox"/> Pain between shoulder blades <input type="checkbox"/> Sharp stabbing pain in mid back <input type="checkbox"/> Dull ache in mid back <input type="checkbox"/> Pain from front to back <input type="checkbox"/> Pain over kidney area <input type="checkbox"/> Muscle spasms in mid back <input type="checkbox"/> Low back pain <input type="checkbox"/> Low back feels out of place <input type="checkbox"/> Muscle spasms in low back <input type="checkbox"/> Pain in buttocks <input type="checkbox"/> Pain down leg R L <input type="checkbox"/> Knee pain R L <input type="checkbox"/> Leg cramps R L <input type="checkbox"/> Pins & needles in legs R L <input type="checkbox"/> Numbness in leg R L <input type="checkbox"/> Cold feet R L <input type="checkbox"/> Swollen ankles R L <input type="checkbox"/> Swollen feet R L
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Skin/Hair/Nails/Eyes/Ears/Nose/Nasopharynx/Sinuses/Mouth and Throat/Genitourinary/Venereal Disease/Other

<input type="checkbox"/> Eczema <input type="checkbox"/> Itchy skin <input type="checkbox"/> Dry scalp <input type="checkbox"/> Oily scalp <input type="checkbox"/> Rough, scaly skin <input type="checkbox"/> Oily skin <input type="checkbox"/> Dry skin <input type="checkbox"/> Psoriasis <input type="checkbox"/> Yellow skin <input type="checkbox"/> Bruise easily <input type="checkbox"/> Paper thin nails <input type="checkbox"/> Pale skin <input type="checkbox"/> Nail biting <input type="checkbox"/> Baldness <input type="checkbox"/> Blurring of vision <input type="checkbox"/> Double vision <input type="checkbox"/> Eyes fatigue easily <input type="checkbox"/> Excessive tearing <input type="checkbox"/> Lack of tearing <input type="checkbox"/> Light bothers eyes <input type="checkbox"/> Excessive itching <input type="checkbox"/> Pain in eyeball	<input type="checkbox"/> Loss of hearing <input type="checkbox"/> Pain in ears <input type="checkbox"/> Discharge from ears <input type="checkbox"/> Vertigo <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Unusual nasal discharge <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Pressure over eyes <input type="checkbox"/> Pressure under eyes <input type="checkbox"/> Obstruction of nose <input type="checkbox"/> Frequent colds <input type="checkbox"/> Sinusitis <input type="checkbox"/> Nasal allergies <input type="checkbox"/> Loss of sense of smell <input type="checkbox"/> Any trauma to nose <input type="checkbox"/> Pain of mouth <input type="checkbox"/> Pain of throat <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Cavities <input type="checkbox"/> Loss of sense of taste <input type="checkbox"/> Crave sweets <input type="checkbox"/> Crave salt	<input type="checkbox"/> Abscessed teeth <input type="checkbox"/> Dentures <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Changes in voice <input type="checkbox"/> Urination is frequent <input type="checkbox"/> Urination is normal <input type="checkbox"/> Urination is infrequent <input type="checkbox"/> The amount of urination is high <input type="checkbox"/> The amount of urination is normal <input type="checkbox"/> The amount of urination is low <input type="checkbox"/> Need to get up at night to urinate <input type="checkbox"/> Abnormal intense desire to urinate <input type="checkbox"/> Difficulty starting urination <input type="checkbox"/> Decreased output <input type="checkbox"/> Pain upon urination <input type="checkbox"/> Dribbling <input type="checkbox"/> Blood in urine <input type="checkbox"/> Cloudy urine <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Syphilis <input type="checkbox"/> Gonorrhea
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Current Medications

Reason for taking

Surgeries:

Date

Type of Surgery

Females:

Pregnancies/Date of Delivery

Outcome

What was the date of the beginning of your last menstrual period? _____ Do you have painful periods? ___ Yes ___ No
Do you have premenstrual symptoms? ___ Yes ___ No Do you have vaginal discharge? ___ Yes ___ No
Do you have spotting? ___ Yes ___ No Do you have irregular periods? ___ Yes ___ No
Do you have menstrual cramps? ___ Yes ___ No Do you have lumps in your breasts? ___ Yes ___ No

Family Health History:

Associated health problems of relatives: _____

Deaths in immediate family:

Cause of parents or siblings death

Age at death

Children's Names and Ages: _____

Social and Occupational History:

Job description: _____

Work schedule: _____

Recreational activities: _____

Lifestyle (hobbies, level of exercise, diet): _____

PATIENTS NEED TO BE AWARE:

- Services that are not covered by insurance and must be paid in full at the time of rendering are Avatar testing, Bio-Ray treatments, IV chelation therapy, supplements, and consults by the doctor that are not nutritional or spinal in nature.
- We ask our patients to give us 24 hours notice of an appointment cancellation. With discretion, we reserve the right to charge for the time allotted for these appointments if proper notice was not given.

I have read the information on these pages and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of to provide me with care, in accordance the doctor's licensures and with this state's statutes.

Patient or Parent/Guardian Signature _____ Date _____ CaseHistory.doc