



## PATIENT HISTORY

**Please check  Symptoms you currently have:**

- |  |  |  |  |   |
|--|--|--|--|---|
| <input type="checkbox"/> Dizziness/Vertigo   | <input type="checkbox"/> Nausea/Vomiting                         | <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Chest pain                                    | <input type="checkbox"/> Night sweats                             |
| <input type="checkbox"/> Pain wakes you from sleep                                   | <input type="checkbox"/> Lose weight without trying              | <input type="checkbox"/> Headaches for hours or days | <input type="checkbox"/> Coughing up blood/blood in stool/urine        | <input type="checkbox"/> History of stroke in your family         |
| <input type="checkbox"/> Loss of bladder or bowel control                            | <input type="checkbox"/> Pain in neck, jaw or face               | <input type="checkbox"/> Sore that does not heal     | <input type="checkbox"/> Unusual bleeding or discharge                 | <input type="checkbox"/> Drooping eyelid or change in your pupils |
| <input type="checkbox"/> Pain in any wart or mole                                    | <input type="checkbox"/> Change in any wart or mole              | <input type="checkbox"/> Nagging cough or hoarseness | <input type="checkbox"/> Double vision/ lost sight in one eye Diplopia |   |
| <input type="checkbox"/> Ringing in your ears  | <input type="checkbox"/> Thickening in your breasts or elsewhere |  | <input type="checkbox"/> Difficulty arranging words properly/Dysphagia |   |
| <input type="checkbox"/> Drop attacks/faint, pass out easily/loss of consciousness   |  |  | <input type="checkbox"/> Numbness on one side of face or body          |   |
| <input type="checkbox"/> Difficult or slurred speech/Dysarthria                      |  |  | <input type="checkbox"/> Headache/head pain unlike ever experience     |   |
| <input type="checkbox"/> Difficulty walking/coordination/ falling to one side Ataxia |  |  |  |   |
| <input type="checkbox"/> Nystagmus/visual disturbances or rapid eye movement         |  |  |  |   |

**Please check  conditions or symptoms you currently have or have had in the past:**

- |                                       |  |  |   |  |
|---------------------------------------|--|--|---|--|
| <input type="checkbox"/> AIDS/HIV     | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Herniated Disk      | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Anemia       | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Pinched nerve        | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Anorexia     | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Ulcers          |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Polio                | <input type="checkbox"/> Varicose Veins  |
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Jaw Pain/TMJ        | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Whiplash        |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Blood Clots  | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Rheumatoid Arthritis | _____                                    |
| <input type="checkbox"/> Breast Lump  | <input type="checkbox"/> Gout                | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Rheumatic Fever      | _____                                    |
| <input type="checkbox"/> Bronchitis   | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Scarlet Fever        | _____                                    |
| <input type="checkbox"/> Bulimia      | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Stroke               | _____                                    |
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Thyroid Problems     | _____                                    |

|   |   |   |
|---|---|---|
| <b>EXERCISE</b><br><input type="checkbox"/> None<br><input type="checkbox"/> Daily<br><input type="checkbox"/> Moderate<br><input type="checkbox"/> Heavily | <b>WORK ACTIVITY</b><br><input type="checkbox"/> Sitting<br><input type="checkbox"/> Standing<br><input type="checkbox"/> Light Labor<br><input type="checkbox"/> Heavy Labor | <b>LIFE STYLE</b><br><input type="checkbox"/> Smoking Packs/Day _____<br><input type="checkbox"/> Coffee/Caffeine Cups/Day _____<br><input type="checkbox"/> Alcohol Drinks/Week _____<br><input type="checkbox"/> High Stress Level Reason _____ |
|---|---|---|

**FEMALE ONLY:** When was your last period? \_\_\_\_\_ Are you pregnant?  Yes  No  Not Sure

| Injuries/Surgeries you have had: | Description | Date  |
|----------------------------------|-------------|-------|
| Accidents/Falls _____            | _____       | _____ |
| Head Injuries _____              | _____       | _____ |
| Broken Bones _____               | _____       | _____ |
| Dislocations _____               | _____       | _____ |
| Surgeries _____                  | _____       | _____ |

| MEDICATIONS | Reason | ALLERGIES | VITAMINS/HERBS/MINERALS |
|-------------|--------|-----------|-------------------------|
| _____       | _____  | _____     | _____                   |
| _____       | _____  | _____     | _____                   |
| _____       | _____  | _____     | _____                   |

\*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Consent to Treat a Minor: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse's Signature of Authorizing care: \_\_\_\_\_ Date: \_\_\_\_\_

**If this is an accident related injury, please fill out the Accident Form. THANK YOU!**