	AGE	LIVING O	R DECEASED	HEALTH	PROBLEMS OR CAUSE OF DEAT
Mother					
Father					
Brother (s)					
Sister (s)					
SOCIAL F	HISTORY	Y			
obacco use?	How M	luch?	How Ofte	en?	For How Long?
Alcohol use? How Much?		How Ofte	en?	For How Long?	
affeine use?	How M	uch?	How Oft	en?	For How Long?
rug use?	Yes () N	(o ()		
hat type of	work do	you do?			4
			1		
MEDICAL	HISTOF	RY			
ave you eve	er had s	urgery? I	f yes, please li	ist the sur	rgery including dates:
					_
					

		Rev	iew of Symptoms Checklist		
,	Are γου currently experienc	ing any of th	ese symptoms? (check all t	hat apply)	
	Constitutional		Respiratory		Neurological
U	n Fever		ı Cough		Dizziness
(,	a Chills		Hemoptysis		Tingling
C			Sputum production	[2]	Tremor
C	/		Shortness of breath		Sensory change
(:	Diaphoresis	C	Wheezing		Speech change
ľ.	ı Weakness				Focal weakness .
			Gastrointestinal		Selzures
	Skin	1.3	Heartburn		Loss of consciousness
	Rash	[]	Nausea		
	Itching	(二)	Vomiting		Psychlatric
			Abdominal pain		Depression
	HENT		Diarrhea		Sulcidal ideas
Ω	Headaches	D	Constipation		Substance abuse
	Tinnitus		Melena		Hallucinations
	•				Nervous/Anxious
	Ear discharge		Genitourinary	O	Insomnia
	Nosebleeds	٥	Dysuria		Memory loss
	Congestion	O	Urgency		
	Stridor		Frequency		
	Sore throat		Hematurla		
			Flank pain		
	Eyes				
ĽI	Blurred vislon		Musculoskeletal		
	Double vision	(3)	Myalgias		
\Box	Photophobla		Neck pain		
	Eye pain		Back pain		
	Eye discharge	Ω	Joint pain		
IJ	Eye redness	a	Falls		
	Cardiovascular		Endo/Heme/Allergies		
ניו	Chest pain	(1)	Easy bruise/bleed		
C)	Palpitations	[]	Enviro, allergies		
	Orthopnea		Polydipsia		
O	Claudication				

DOB:

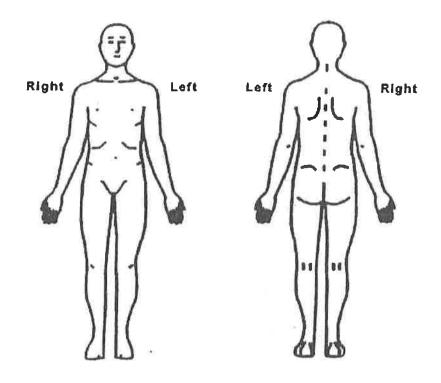
Patient's Name:

☐ Leg swelling ☐ PND

ient's Name;	DOB:	

New Patient Questionnaire

Shade in the area(s) where you have pain. Put an 'X' on the area that hurts the most.



When did the pain start? _____

I have pain ... (circle one)

Seldom	Few times a	Few times a	Daily, but not	All the time
	month	week	all the time	

Indicate on this line how bad your pain is – the left end of the line means no pain at all, the right end of the line means the worst possible pain.

No Pain

Worst Possible Pain

Please circle the following items that you have tried in the past to help with the issue we are seeing you for today.

Low impact exercise	Avoidance of activities that cause pain	Heat/Cold modalities	Chiropractic/Manipulation	
Spine school	Acupuncture	Massage Therapy	Physical Therapy	
Pain Medications	Anti-inflammation medications	TENS Therapy	Nerve Blocks	
Muscle Relaxants	Caudal Blocks	Facet Blocks	Epidural Injections	