Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone No.: _____

Email Address: _____

Age: _____ Date of Birth: _____ Sex: _____ Male _____ Female

Height: _____ Weight: _____

Occupation: _____ Employer: _____

Marital Status: ____ S ____M ____D ____W Name of Spouse: _____

Family Physician's name: _____ Physician's Phone No.: _____

Emergency Contact: _____ Phone No.: _____

How did you hear about us? Referral by: _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

What are your chief complaints/concerns for this visit?

_____

_____

Since when? _____

How would you rate your discomfort? (1=Low, 10=Extreme) _____

Doctors seen for this complaint: _____

Current prescription medications, OTC medications or supplements **(Please type clearly)**.

Medications or Vitamin Supplements	**Diagnosis/Symptoms**
_____	_____
_____	_____
_____	_____
_____	_____

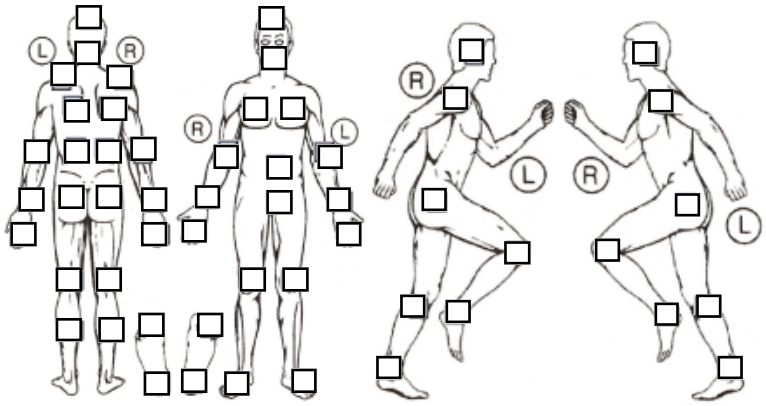
_____ Yes _____ No I have been evaluated by a physician or a dentist for the condition to be treated within six months.

If your today's visit is due to pain, please provide the following information:

__ Burning	__ Tingling	__ Throbbing	__ Stiffness
__ Constant	__ Dull	__ Tenderness	__ Swelling
__ Numbness	__ Distention	__ Cold Feeling	__ Tremor
__ Sharp	__ Heaviness	__ Warm/Hot Feeling	__ Worsening
__ Stabbing	__ Spasmodic	__ Intermittent	

How would you rate your Pain level? _____ (1=Low, 10=Extreme) _____

Please clearly mark any areas of <u>pain</u> and any <u>scars</u> (please indicate which of the area are scars):



HISTORY:

List any major illnesses (with approx. dates): _____

List any surgery or operations with approx. date: _____

Past Accidents or injuries: _____

Describe health of spouse: _____ Number of children if any: _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	_____	____M ____ F	____ _____
_____	_____	____M ____ F	____ _____
_____	_____	____M ____ F	____ _____

Any family history of serious illnesses (circle those which apply): ____ Cancer ____ Diabetes ____ Heart ____Other ____

_____

Any household pets or other animals you or family members are in close contact with: _____

_____

What can we do to make you happier? _____