

HEALTHCARE PROFESSIONALS

Please list any healthcare professionals or non-healthcare professionals involved in your care. Include physicians, physician's assistants, chiropractors, physical therapists, homeopathic physicians, etc.

Primary care physician:

NAME	SPECIALTY / PROFESSION	TELEPHONE #

Non-healthcare professionals such as insurance contact person, attorney

NAME	SPECIALTY / PROFESSION	TELEPHONE #

Please indicate with a which of the above caretakers you would like to receive a record of your examination and treatment plan. The requesting professional, as well as the primary care physician (if not the same), will automatically receive reports unless otherwise specified.

Medications – List all medications taken regularly

NAME	DOSE	HOW OFTEN	HOW LONG	PRESCRIBED BY

Pharmacy: _____ Telephone #: _____

Allergies: _____

FAMILY HISTORY

Please list the health status or cause of death of your:

Father: _____

Mother: _____

Brothers: _____

Sisters: _____

Has any "blood-related" relative had a similar problem to the one you are having? _____

Are there any hereditary diseases in your family that you are aware of? _____

SOCIAL HISTORY

Are you married? Yes No

If no, have you ever been married? Yes No

Do you have children? Yes No

What is your occupation? _____

Do you consider your diet "healthy"? Yes No

Do you (or did you before your problem began) regularly "work out", run, or play any sports? Yes No

Have you been diagnosed with a psychiatric condition? Yes No If yes, explain: _____

Do you have a history of substance abuse? Yes No If yes, what substance? _____

Do you currently smoke cigarettes? Yes No

If you do smoke cigarettes, how much? _____ packs per day for _____ years

If you formerly smoked cigarettes, how long has it been since you quit? _____

Approximately how often do you consumer alcohol?

Never 1-2 times per year 1-2 times per month 1-2 times per week daily

REVIEW OF SYSTEMS

Please note any problems you are having in areas listed:

Head: _____ Heart: _____

Ears: _____ Lungs: _____

Eyes: _____ Stomach / Intestines: _____

Nose: _____ Genitals / Urinary Tract: _____

HAND / WRIST

Describe the type of discomfort (numb, tingling, pain, ache, "electric," hot, etc.). Which hand? left right both

Hand: _____ Wrist / forearm (to elbow): _____

Are there times when you have little or no discomfort? Yes No

When (time of day or night) is the discomfort worst? _____

What makes it better? _____

Rate your discomfort level (check one):

None 1 2 3 4 5 6 7 8 9 10 *Worst*

Have you noticed any weakness? If so, which hand? left right both

What movements or actions? _____

Has the problem improved become better or worsened since it began?

Any other comments? _____

NECK / ARM

Describe the type of discomfort (numb, tingling, pain, ache, "electric," hot, etc.). If arm, which one? left right both

Neck: _____ Arm: _____

Are there times when you have little or no discomfort? Yes No

When (time of day or night) is the discomfort worst? _____

What makes it better? _____

Rate your discomfort level (check one):

None 1 2 3 4 5 6 7 8 9 10 *Worst*

Have you noticed any weakness? If so, which arm? left right both

What movements or actions? _____

Have you noticed unexpected stumbling or painless weakness of your legs? Yes No

Has the problem improved become better or worsened since it began?

Any other comments? _____

BACK / LEG

Describe the type of discomfort (numb, tingling, pain, ache, "electric," hot, etc.).

If leg, which one? left right both

Back: _____ Leg: _____

Are there times when you have little or no discomfort? Yes No

When (time of day or night) is the discomfort worst? _____

What makes it better? _____

Rate your discomfort level (check one):

None 1 2 3 4 5 6 7 8 9 10 *Worst*

Have you noticed any weakness? If so, which leg? left right both

What movements or actions? _____

Has the problem improved become better or worsened since it began?

Any other comments? _____
