Patient's Name: Date:

Vitals

Height: _____ Weight: _____ Age: _____

Who referred you to this office? _____

Reason for your visit

Reason for today's visit: _____ Right or Left:_____

Date of Injury/ Onset: _____ How did this occur? _____

Where did injury occur? School _____ Work _____ Auto _____ Home _____ Other: _____

Rate of Pain 1-10 (1<10>) _____ What makes pain worse or better? _____

Have x-rays been taken? _____ When? _____ Where? _____

Recreational Activities:

_____

_____

_____

Surgical History (List Any Surgeries within the past 10 years)

Date	Type of Surgery	Complication	Doctor

Social History

Do you smoke? YES NO How many years? _____ How many packs per day? _____

Did you quit smoking? YES NO

Do you drink? YES NO How frequently? _____

Medications

- **I am not taking any medications.**

_____

_____

_____

_____

Allergies

- **I have NO drug allergies.**

_____

_____

Patient's Name: Date:

Have you ever been treated for any of the following? Please select response by filling the bubble (●).

	Yes	No
Heart Problems	O	O
Circulatory Problems	O	O
Hepatitis, jaundice or liver disease	O	O
Stomach ulcers	O	O
Thyroid disease	O	O
Stroke	O	O
Asthma	O	O
Cardiac pacemaker	O	O
Arthritis	O	O
Anemia	O	O
Emphysema	O	O
Seizures	O	O
Cancer	O	O
AIDS/HIV	O	O
Kidney problems	O	O
Gout	O	O
Hearing problems	O	O
Tuberculosis	O	O
Coughing blood	O	O
Depression	O	O
Pregnant at present	O	O
Regular menses	O	O
Diabetes	O	O
Take insulin?	O	O

How Long	O	Six Month	O	Less than a year
	O	More than a year	O	other_____