



# INITIAL VISIT MEDICAL HISTORY

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

## SYMPTOMS

Describe your symptoms: \_\_\_\_\_

When did the symptom begin? \_\_\_\_\_

Is this a result of an accident or injury?  Yes  No

**IMPORTANT: If you answered "yes" to the above question, describe the incident in detail below:**

1. What occurred? \_\_\_\_\_

2. When did it occur? \_\_\_\_\_

3. Where did it occur? \_\_\_\_\_

## PAIN

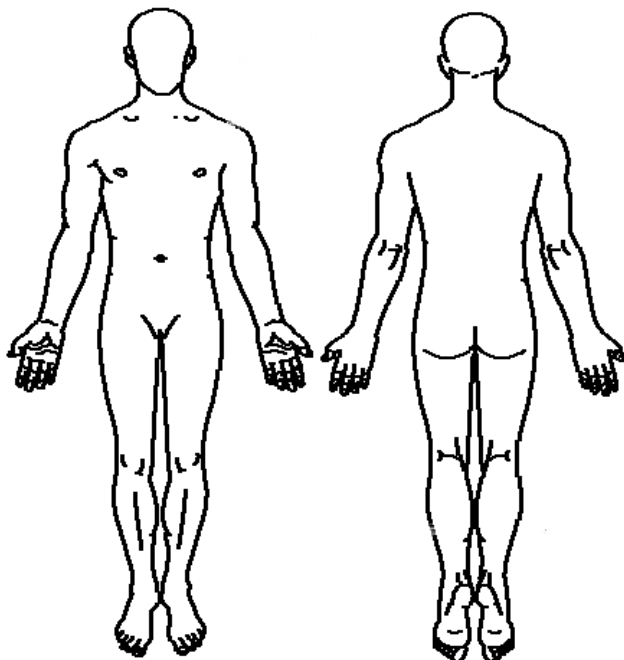
What makes the pain better? \_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

List the tests that you have had done: (x-rays, CAT scans, MRI scans, etc.) \_\_\_\_\_

List the treatment you have had for this condition: (medication, physical therapy, chiropractic, injections, surgery, etc.) \_\_\_\_\_

PLEASE SHADE IN THE AREA OF YOUR PAIN USING THE SYMBOLS BELOW:



- Aching <<<<<
- Sharp ^ ^ ^ ^
- Pins & Needles \* \* \* \*
- Numbness X X X X
- Dull 0 0 0 0
- Burning / / / /

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### PAST MEDICAL HISTORY

Do you have any of the following conditions?

*If so, please check the box.*

- None
- Diabetes
- Liver Disease
- Fever or Chills
- Thyroid Disease
- Cancer
- Problems with Anesthesia
- Fractures
- Blood Clots
- Heart Disease
- High Blood Pressure

Other / Comments: \_\_\_\_\_

### FAMILY HISTORY

Has your immediate family had any of the following conditions? *If so, please check the box.*

- None
- Bleeding Disorder
- Problems with Anesthesia
- Heart Disease
- Diabetes
- Cancer
- Scoliosis
- Multiple Fractures

Other / Comments: \_\_\_\_\_

### SOCIAL HISTORY

Do you smoke?  Yes  No

How many packs a day? \_\_\_\_\_

Do you drink alcohol?  Yes  No

How much a day? \_\_\_\_\_

### SURGERIES

This section does not apply.

List all surgeries you have had and include the year in which the surgery was performed.

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### MEDICATIONS

Please list the name, dosage, and frequency of all medications you are taking. Check "none" if you are not on any regular medications.

None

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### REVIEW OF SYSTEMS

Tell us about your health in general. Do you have any of the following? If so, please check the box.

- None
- Fever or Chills
- Chest Pain
- Dizziness
- Difficulty Breathing
- Shortness of Breath
- Irregular Heartbeat
- Headaches / Migraines
- Mood Changes
- Swelling of Legs
- Bleeding Disorder
- Joint Pain
- Muscle Pain / Cramps
- Change in Appetite
- Weight Gain or Loss
- Vision Changes
- Nausea / Vomiting
- Diarrhea / Constipation
- Stomach Ulcers
- Frequent Urination

Other / Comments: \_\_\_\_\_

### ALLERGIES

Please list any medicine you are allergic to:

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Nurse's signature upon review

Date