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SYMPTOMS

How did this happen?/What caused this? _____
When did you first notice the symptoms? _____ Is this condition getting worse? _____
Where is the problem(s) located? _____
Type of pain: ☐ sharp ☐ dull ☐ throbbing ☐ numbness ☐ aching ☐ shooting ☐ burning ☐ tingling ☐ cramps ☐ stiffness ☐ swelling ☐ other: _____
Which activities are difficult to perform? (ie- sitting, standing, walking) _____
Rate the severity of your pain (1, discomfort to 10, unable to walk) 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go? _____
Is there anything that makes it better? _____
What treatment have you received for your condition? _____
Did any of the treatment you received help? _____
Name and contact information for other providers that treated you: _____
_____

DAILY HABITS

What type of exercise do you perform daily? ☐ None ☐ Light ☐ Moderate ☐ Heavy
What do your daily work habits include? (sitting, standing, light labor, heavy labor, computer work?)
_____
_____
_____
_____
What vitamins or supplements do you take daily? _____
Do you smoke? ☐ Yes ☐ No How often do you consume alcoholic beverages? ☐ Daily ☐ Weekly ☐ Monthly ☐ N/A
How much caffeine do you consume daily? _____

HEALTH HISTORY, PART 1

Date of last physical exam _____
Women only: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No
List surgeries you have had and the year they occurred: _____
_____
_____
_____
Allergies: _____
_____
_____
Please list all medications you are currently taking or provide a list available to photo copy:
_____
_____
_____
_____
_____
_____
_____