

Patient Health Assessment (cont.)

12. Do you exercise?

- No regular exercise 1-2 times a week 3-4 times a week 5-7 times a week
 Cardiovascular Stretching Weight Machine Free Weights Sports _____ Type _____

13. What is your present general stress level:

- No stress Minimal stress Moderate stress Greatly stressed

14. Is your problem affecting your ability to work or do other routine daily activities?

- No effect Have some limited physical restrictions, but can function
 Need some assistance with daily activities Cannot work
 Cannot function without assistance Totally disabled

Past Or Present Symptoms, Conditions Or Habits

Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

Symptom	Past	Present	Symptom	Past	Present
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart condition	<input type="checkbox"/>	<input type="checkbox"/>
Arm/elbow pain	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory condition	<input type="checkbox"/>	<input type="checkbox"/>
Hand pain	<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems	<input type="checkbox"/>	<input type="checkbox"/>
Upper back pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder problem	<input type="checkbox"/>	<input type="checkbox"/>
Lower back pain	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>
Pain in upper leg or hip	<input type="checkbox"/>	<input type="checkbox"/>	Breast soreness/lump	<input type="checkbox"/>	<input type="checkbox"/>
Pain in lower leg or knee	<input type="checkbox"/>	<input type="checkbox"/>	Sinus conditions	<input type="checkbox"/>	<input type="checkbox"/>
Pain in ankle or foot	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/asthma	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/stiffness of joints	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Excessive weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Skin condition	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
General prolonged fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Prostate condition	<input type="checkbox"/>	<input type="checkbox"/>
Condition of uterus/ovaries	<input type="checkbox"/>	<input type="checkbox"/>			

Tobacco use:

- Past Present
 Occasional Moderate Heavy

Alcohol use:

- Past Present
 Occasional Moderate Heavy

Caffeine use: (Coffee, tea, soft drinks)

- Past Present
 Occasional Moderate Heavy

Pregnancy: Past Present

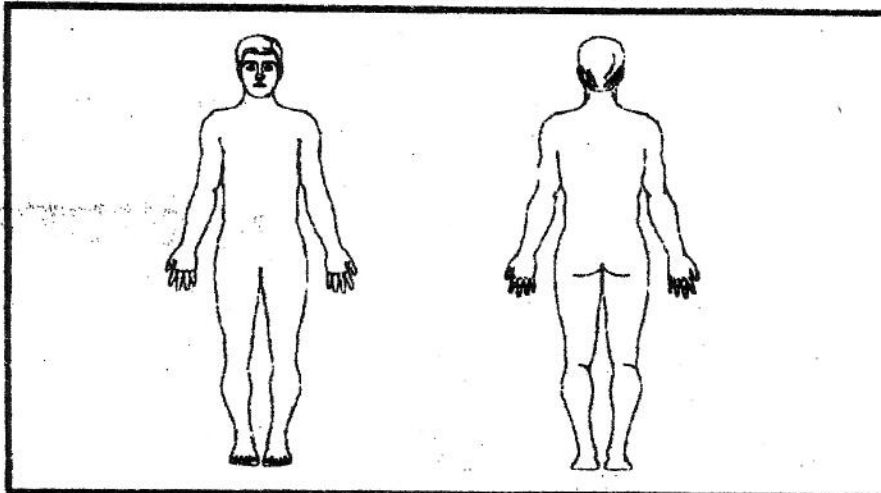
Surgical Procedure:

- Past Present

Please list: _____

Comments: _____

Please shade in the figures below where you have pain, or other symptoms:



I have reviewed the information contained on this form with the patient.

Patient Name _____

Provider initials _____

Date _____