

**CONFIDENTIAL HEALTH INFORMATION**

Today's Date \_\_\_\_\_

Name (Last, First, MI) \_\_\_\_\_ Date of Birth \_\_\_\_\_

**GENERAL INFORMATION**
☐ Male ☐ Female Race \_\_\_\_\_ Height \_\_\_\_\_' \_\_\_\_\_" Weight \_\_\_\_\_lbs

Name of your primary care physician \_\_\_\_\_ Phone \_\_\_\_\_

Are you currently seeing other physicians or therapists for these problems ☐ Yes ☐ No

Are you currently on disability ☐ Yes ☐ No For: \_\_\_\_\_

The reason for this visit: \_\_\_\_\_ as a result of ☐ Work ☐ Accident ☐ Sports ☐ Other

Do you smoke or chew ☐ Yes ☐ No Do you drink alcohol ☐ Never ☐ Socially ☐ Occasionally ☐ Frequently

Do you currently exercise ☐ Never ☐ Occasionally ☐ Regularly ☐ Stopped due to \_\_\_\_\_

**HAVE YOU EVER HAD OR BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS**
☐ Y ☐ N Heart Attack/ Stroke/ TIA

☐ Y ☐ N Diabetes Type I Type II

☐ Y ☐ N Alcohol/Drug Abuse

☐ Y ☐ N Heart Disease or Surgery

☐ Y ☐ N Congestive Heart Failure

☐ Y ☐ N High/Low Blood Pressure

☐ Y ☐ N Pacemaker/ Defibrillator

☐ Y ☐ N Carotid Artery Blockage

☐ Y ☐ N Artificial Bones/Joints

☐ Y ☐ N Osteoporosis

☐ Y ☐ N Arthritis OA or RA

☐ Y ☐ N Fibromyalgia/ Lupus/ MS

☐ Y ☐ N Peripheral Artery Disease

☐ Y ☐ N Neck or Back Pain

☐ Y ☐ N Neck or Back Surgery

☐ Y ☐ N Anemia or Blood Problems

☐ Y ☐ N COPD or Lung Problems

☐ Y ☐ N Hepatitis/ Liver Problems

☐ Y ☐ N Kidney Problems or Failure

☐ Y ☐ N Cancer

☐ Y ☐ N Chemotherapy/ Radiation

☐ Y ☐ N High Cholesterol / High A1C

☐ Y ☐ N Heavy Metal Exposure

☐ Y ☐ N Edema or swelling of legs

☐ Y ☐ N Restless Leg Syndrome

☐ Y ☐ N Neuropathy

Do you have any of the following problems?

Write In: **N** = None **O** = Occasional

**C** = Continuous **F** = Frequent

\_\_\_\_\_ Neck Pain \_\_\_\_\_ Shoulder

\_\_\_\_\_ Mid Back Pain \_\_\_\_\_ Elbow Pain

\_\_\_\_\_ Low Back Pain \_\_\_\_\_ Wrist Pain

\_\_\_\_\_ Sacral Pain \_\_\_\_\_ Hand Pain

\_\_\_\_\_ Pelvis Pain \_\_\_\_\_ Finger Pain

\_\_\_\_\_ Hip Pain \_\_\_\_\_ Thumb Pain

\_\_\_\_\_ Leg Pain \_\_\_\_\_ Whole Body

\_\_\_\_\_ Knee Pain \_\_\_\_\_ Headaches

\_\_\_\_\_ Ankle Pain \_\_\_\_\_ Migraines

\_\_\_\_\_ Foot Pain \_\_\_\_\_ TMJ Pain

\_\_\_\_\_ Toe Pain \_\_\_\_\_ Rib Pain

List other medical conditions you have had \_\_\_\_\_

**Surgeries** (Please list ALL surgical procedures that you have had in the past.) \_\_\_\_\_

**Injuries** (Please list any significant injuries, falls, trauma or non motor vehicle accidents you have had in the past.) \_\_\_\_\_

**Motor Vehicle Accidents** (Please list any past MVA's, year and list injuries sustained.) \_\_\_\_\_

List any **MRI's, Cat Scans, or Pet Scans** in the past. Include date and region \_\_\_\_\_

**FAMILY HISTORY**
**Family**
**Alive**
**Deceased**
**Health Conditions/Diseases/Conditions**

Father

☐
☐

Mother

☐
☐

Paternal Grandfather

☐
☐

Paternal Grandmother

☐
☐

Maternal Grandfather

☐
☐

Maternal Grandmother

☐
☐

Patient Initial \_\_\_\_\_

### Recent Doctor visits or ER visits

Have you been to the ER in the past 6 months ☐ Yes ☐ No If Yes then fill in below

Date	What Hospital /City/ State	Treated For / Treatment

Have you been to the Doctor in the past 6 months ☐ Yes ☐ No If Yes then fill in below

Date	Name of Doctor /City /State	Treated For / Treatment

### Medication Log

Name of Medication	Dosage	Qty	Purpose	Prescribing Physician

### Vitamins and Supplements

Name of Vitamin/ Supplement	Dosage	Qty	Purpose

List anything you may be allergic to \_\_\_\_\_