CONFIDENTIAL PATIENT HISTORY

Name _____

How do you wish to be addressed in our office? ❑First name ❑ Mr ❑ Mrs ❑Ms ❑Miss ❑ Dr

Address _____ City _____ State_____ Zip_____

SSN#_____ Date of Birth _____ Marital Status: Single Married Widowed Divorced

Home Telephone _____ Cell _____ Work_____

Email address: _____

Occupation _____ Employer _____

Spouse/Partner's Name _____ Employer _____

Spouse/Partner's Work Ph_____ Cell Ph _____

Name of person to contact in case of emergency:_____

Relationship:_____ Phone_____

How did you choose our office? (e.g. Referral, internet, advertisement etc.)

_____

What is the main problem or symptom that made you come here today?:

_____

When and How did this begin? _____

Have you had this or similar conditions in the past? ❑Yes ❑No If yes, when? _____

What aggravates your condition? _____

What makes it better? _____

Describe what you are feeling? _____

Do you experience Numbness or Tingling? ❑No ❑Yes If yes, where? _____

SYMPTOM INTENSITY: Please circle the number describing the intensity of your symptoms.

None→ 0 1 2 3 4 5 6 7 8 9 10 **←Unbearable**

When you're awake, how often are you feeling these symptoms?(0-100%) _____%

Is this getting progressively worse? ❑Yes ❑ No **Is your condition:** ❑Constant ❑Comes & goes

Is this condition interfering with your: ❑Work ❑Sleep ❑Daily routine ❑Other _____

Has there been any medical diagnosis of your complaint? ❑ Yes ❑ No If yes, list the Dr.'s name and the Diagnosis _____

How have you tried to take care of this problem in the past? <u>Circle all that apply</u>

Medications • Emergency Room • Surgery • Routine Medical • Exercise • Supplements • Regular Chiropractic

Other (please specify)_____

How did the previous method(s) work out for you? Circle all that apply

Bad results • Some Results • Great Results • Nothing Changed • Didn't get worse • Didn't work very long

What are you afraid this might be? _____

List surgical operations and years: _____

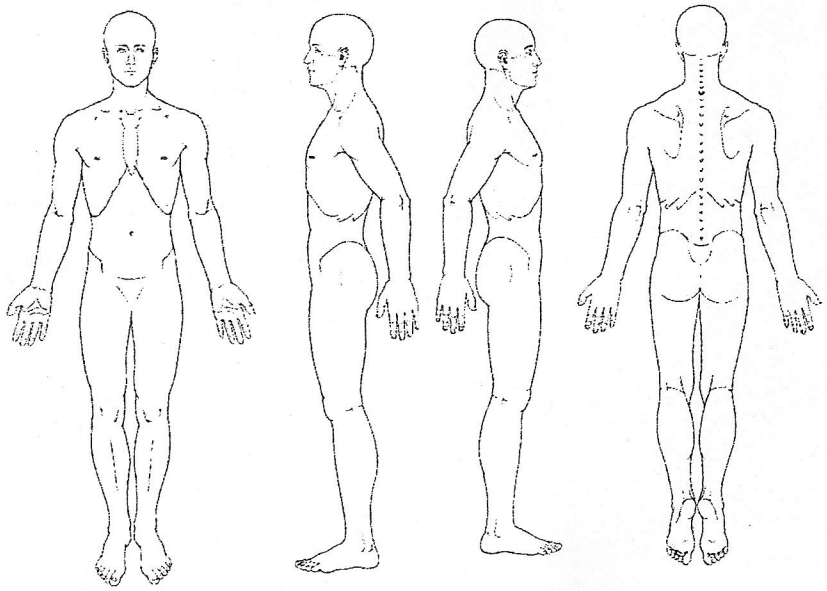
Other Medical or Physical conditions you have been diagnosed with (e.g. diabetes, heart conditions, arthritis, osteoporosis, low thyroid, hormone imbalance, food allergies, anxiety or panic attacks etc.) _____

_____

_____

Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the diagram to accurately describe your problem.

PPP	PAIN
WWW	WEAKNESS
NNN	NUMBNESS
HHH	HEAT
TTT	TINGLING
BBB	BURNING
CCC	CRAMPING
FFF	STIFFNESS



Write "YES" or "NO" in the box next to each of the questions.

	Weakness		Fatigue
	Pins & Needles feelings, electric shock feelings		Racing heart beat
	Trouble controlling bowels or bladder		Angina—chest pain or shortness of breath
	Hair loss on the arms or legs		Left arm pain
	Balance problems		Swelling in the lower legs
	Fingernails are brittle or have ridges or look different		Extreme shortness of breath; feel like drowning / suffocating
	Symptom changes with arm, leg or neck movement		Blackouts
	Twitching muscles		Light headedness
	Decrease in size or tone of your arms or legs		Cramping pains in the legs that start after walking
	Uncoordinated		Poor exercise tolerance
	Muscle cramping		Erectile dysfunction

	Double vision?		Sensitivity to light
	Difficulty talking?		Sweat more on one side (armpit, face etc.)
	You feel unsteady or you fall		Dry mouth
	Vomiting, sick to stomach		Dry eyes
	Abnormal jerking of the eyes		Cold arms, legs, hands, feet
	Numbness? Where?		

Please list any medications you currently take and for what conditions:

_____

_____

Please list any natural supplements you currently take and for what conditions:

_____

_____

Please list your 5 major health concerns in order of importance to you.

1. _____
2. _____
3. _____
4. _____
5. _____

Please use this space to give us more details about the history of your problem(s).
Please tell us about:

- When these problems started? How have they changed over time?
- What have you tried to help this (medications, therapies, diets, supplements etc.)
- What was the response? (helped, worse, no change)
- What do you think makes these symptoms/behaviors worse?
- What do you think makes these symptoms/behaviors better.
- TELL US AS MUCH AS YOU CAN!! USE EXTRA PAPER IF NECESSARY

_____

_____

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_____

Past Evaluations

Here is a list of possible testing and evaluations you may have. If you have any of these please make sure to send copies of these results and reports with this questionnaire. (We do not need daily office notes).

- MRI, CT, EEG
- Psychological / Neuropsychological Evaluations
- Psychiatric
- Neurological Evaluations
- Gastroenterology Evaluations
- Rheumatology Evaluations
- Internal Medicine Evaluations
- Genetic Evaluations
- Celiac/Gluten testing

Hospitalizations

Age	Reason for Hospitalization	Discharge Summary Attached?

Age	Operations	
	Appendix	
	Hernia	
	Tonsils	
	Adenoids	
	Tubes in Ears	
	Other Surgery:	
	Other Surgery:	

Please describe any head injuries, broken bones or other injuries/ traumas	Age

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific _____

What would be different/better without this problem? Please be specific _____

_____

What do you desire most to get from working with us? _____

_____

What is that worth to you? _____

_____

What is your idea of the ideal doctor? _____

_____

_____

We thank you for your patience and cooperation in completely filling out this form.

Patient's Signature: _____ **Date:** _____

For Doctor's Use Only