

# Confidential Patient Health Record

Today's Date: \_\_\_/\_\_\_/\_\_\_

**How did you hear about us?**  Family \_\_\_\_\_  Friend \_\_\_\_\_  Co-Worker \_\_\_\_\_  
 Close to home/work  Dr. \_\_\_\_\_  Yellow pages  Drove by  Hospital  Insurance Plan

## Personal Information

Title:  Mr.  Ms.  Mrs.  
Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Suffix:  Jr  Sr  II  III  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: Male / Female  
Marital Status:  Single  Married  Widowed  Divorced  Separated  
Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_ County: \_\_\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_  
Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_  
Email Address: \_\_\_\_\_ Spouses Name: \_\_\_\_\_  
Children (Names and Ages): \_\_\_\_\_

## Emergency Contact

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Relationship:  Spouse  Relative  Friend  Other \_\_\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_  
Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

## Employment Information

Business Name: \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Occupation/Job Title: \_\_\_\_\_ Job Description \_\_\_\_\_

## Insurance Information:

Who Is Responsible For Your Bill?  YOU and... (mark appropriate box(es))  Myself ONLY  
 Spouse  Worker's Comp  Auto Insurance  Medicare  Medicaid  Other (be specific): \_\_\_\_\_  
Personal Health Insurance Carrier: \_\_\_\_\_ Health ID Card #: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy Holder's Date of Birth: \_\_\_-\_\_\_-\_\_\_ Primary Care Physician: \_\_\_\_\_

## Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer?  Yes  No Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_ am/pm  
Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_  
Carriers Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Adjuster: \_\_\_\_\_  
Claim #: \_\_\_\_\_

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Current Complaint

What is your current complaint? (why are you seeking treatment?) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**How severe is this problem?**

- Mild
- Mild to Moderate
- Moderate
- Moderately Severe
- Severe

**How Frequently?**

- Constant
- Occasional
- Intermittent
- Frequent

**On a 1-10 scale, how would you rate your pain?  
(10=most painful, 1=least painful)**

- |                            |                            |                             |
|----------------------------|----------------------------|-----------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 5 | <input type="checkbox"/> 9  |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 6 | <input type="checkbox"/> 10 |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 7 |                             |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 8 |                             |

**Improvement (%)**

- |                              |                               |
|------------------------------|-------------------------------|
| <input type="checkbox"/> 10% | <input type="checkbox"/> 60%  |
| <input type="checkbox"/> 20% | <input type="checkbox"/> 70%  |
| <input type="checkbox"/> 30% | <input type="checkbox"/> 80%  |
| <input type="checkbox"/> 40% | <input type="checkbox"/> 90%  |
| <input type="checkbox"/> 50% | <input type="checkbox"/> 100% |

**When was the onset of this problem?**

- |                                    |  |   |
|------------------------------------|--|---|
| <input type="checkbox"/> gradual   | <input type="checkbox"/> about a day ago   | <input type="checkbox"/> several months ago |
| <input type="checkbox"/> sudden    | <input type="checkbox"/> several days ago  | <input type="checkbox"/> about a year ago   |
| <input type="checkbox"/> insidious | <input type="checkbox"/> about a week ago  | <input type="checkbox"/> several years ago  |
|                                    | <input type="checkbox"/> several weeks ago |   |
|                                    | <input type="checkbox"/> about a month ago |   |

**Select each choice that applies to you**

**Movement**

- Cramps
- Inflexibility
- Restricted Movement
- Spasm
- Stiffness

**Sensation**

- Crawling
- Dead
- Numb
- Pins and needles
- Prickly
- Tingling

**Select the type of pain that best describes your complaint**

- |                                       |                                    |                                    |
|---------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Achy         | <input type="checkbox"/> Numb ache | <input type="checkbox"/> Shooting  |
| <input type="checkbox"/> Burning      | <input type="checkbox"/> Pounding  | <input type="checkbox"/> Stabbing  |
| <input type="checkbox"/> Dull         | <input type="checkbox"/> Pulsating | <input type="checkbox"/> Stinging  |
| <input type="checkbox"/> Excruciating | <input type="checkbox"/> Sharp     | <input type="checkbox"/> Throbbing |

**Please indicate everything that makes you feel better**

- usually better in the morning
- usually better during the day
- usually better at night

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please indicate everything that makes you feel worse or aggravates your condition**

- usually worse in the morning
- usually worse during the day
- usually worse at night

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Treatment and Diagnostic History

**Diagnostic tests that have been performed for the current chief complaint include:**

<b>Test 1</b> <input type="checkbox"/> X-Rays <input type="checkbox"/> Lab work <input type="checkbox"/> CT Scan <input type="checkbox"/> Discogram <input type="checkbox"/> MRI <input type="checkbox"/> Bone Scan <input type="checkbox"/> Electrodiagnostics	<b>Body Area</b> <input type="checkbox"/> Skull <input type="checkbox"/> TMJ <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Shoulders <input type="checkbox"/> Left Elbow <input type="checkbox"/> Right Elbow <input type="checkbox"/> Elbows <input type="checkbox"/> Left Wrist <input type="checkbox"/> Right Wrist	<input type="checkbox"/> Wrists <input type="checkbox"/> Left Hand <input type="checkbox"/> Right Hand <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Pelvis	<input type="checkbox"/> Left Hip <input type="checkbox"/> Right Hip <input type="checkbox"/> Hips <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Knee <input type="checkbox"/> Knees	<input type="checkbox"/> Left ankle <input type="checkbox"/> Right Ankle <input type="checkbox"/> Ankles <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Foot <input type="checkbox"/> Feet
---	--	---	---	---	--

**Date of Test:**    /    /  
**Where were the tests performed?** \_\_\_\_\_  
**What were the findings? (if known)** \_\_\_\_\_

<b>Test 2</b> <input type="checkbox"/> X-Rays <input type="checkbox"/> Lab work <input type="checkbox"/> CT Scan <input type="checkbox"/> Discogram <input type="checkbox"/> MRI <input type="checkbox"/> Bone Scan <input type="checkbox"/> Electrodiagnostics	<b>Body Area</b> <input type="checkbox"/> Skull <input type="checkbox"/> TMJ <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Shoulders <input type="checkbox"/> Left Elbow <input type="checkbox"/> Right Elbow <input type="checkbox"/> Elbows <input type="checkbox"/> Left Wrist <input type="checkbox"/> Right Wrist	<input type="checkbox"/> Wrists <input type="checkbox"/> Left Hand <input type="checkbox"/> Right Hand <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Pelvis	<input type="checkbox"/> Left Hip <input type="checkbox"/> Right Hip <input type="checkbox"/> Hips <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Knee <input type="checkbox"/> Knees	<input type="checkbox"/> Left ankle <input type="checkbox"/> Right Ankle <input type="checkbox"/> Ankles <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Foot <input type="checkbox"/> Feet
---	--	---	---	---	--

**Date of Test:**    /    /  
**Where were the tests performed?** \_\_\_\_\_  
**What were the findings? (if known)** \_\_\_\_\_

**Prior Physician:** \_\_\_\_\_  
**Physician's Diagnosis:** \_\_\_\_\_  
\_\_\_\_\_

**Date of 1st Visit:**    /    /  
**Date of Last Visit:**    /    /  
**Treatment Started**    /    /  
**Treatment Stopped**    /    /

**Recommended Treatments Received:** \_\_\_\_\_

<input type="checkbox"/> Plan was not followed <input type="checkbox"/> Offered no relief or benefit <input type="checkbox"/> Relieved the condition	<input type="checkbox"/> Employer sent the patient for treatment
<input type="checkbox"/> Aggravated the condition <input type="checkbox"/> Had some success	<input type="checkbox"/> Patient sought treatment alone

**Treatment Recommended but not Received:** \_\_\_\_\_  
Recommended by: \_\_\_\_\_

**Does the patient treat himself/herself?**     Yes     No

**Out of all treatments received, which offer the most relief?** \_\_\_\_\_  
\_\_\_\_\_

**How long do the benefits last?**  
 briefly     most of the day     a few weeks  
 an hour     several days     a month  
 several hours     a week     several months

<b>Treatment Recommended by Prior Physician (mark all that apply)</b> <input type="checkbox"/> Adjustments <input type="checkbox"/> Immobilization <input type="checkbox"/> Analgesics <input type="checkbox"/> Nerve Blocks <input type="checkbox"/> Bed Rest <input type="checkbox"/> Massage <input type="checkbox"/> Anti-Biotics <input type="checkbox"/> Sedatives <input type="checkbox"/> Heat <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Anti-Inflammatories <input type="checkbox"/> Trigger Point Injections <input type="checkbox"/> Ice <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Muscle Relaxants <input type="checkbox"/> Surgery	<b>Treatment Results (mark one)</b> <input type="checkbox"/> Plan was not followed <input type="checkbox"/> Had some success <input type="checkbox"/> Aggravated the condition <input type="checkbox"/> Relieved the condition <input type="checkbox"/> Offered no relief or benefit
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# Health History

Name:

Chart #:

Today's Date:

Date of Onset:

Please select all choices that apply to the patient.

- |  |  |   |   |   |   |
|--|--|---|---|---|---|
| <input type="checkbox"/> Abdominal Pain  | <input type="checkbox"/> Colitis           | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Irritable Colon    | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Sinus Trouble        |
| <input type="checkbox"/> Allergies       | <input type="checkbox"/> colon cancer      | <input type="checkbox"/> Heart Attacks          | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Painful Urination    | <input type="checkbox"/> Spinal Disc Disorder |
| <input type="checkbox"/> Angina          | <input type="checkbox"/> Convulsions       | <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Kidney Stones      | <input type="checkbox"/> peptic ulcer         | <input type="checkbox"/> STDs                 |
| <input type="checkbox"/> Anorexia        | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> hepatitis A            | <input type="checkbox"/> kyphosis           | <input type="checkbox"/> PMS                  | <input type="checkbox"/> stomach cancer       |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> juvenile diabetes | <input type="checkbox"/> hepatitis B            | <input type="checkbox"/> leg pain           | <input type="checkbox"/> Polio                | <input type="checkbox"/> stomach ulcer        |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> adult diabetes    | <input type="checkbox"/> hepatitis C            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Profuse Menstrual    | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Dislocated Joints | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> lordosis           | <input type="checkbox"/> prostate cancer      | <input type="checkbox"/> Thyroid Disorder     |
| <input type="checkbox"/> Blood Disorder  | <input type="checkbox"/> Dizziness         | <input type="checkbox"/> hip pain               | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> traumatic arthritis  |
| <input type="checkbox"/> Bone Cancer     | <input type="checkbox"/> duodenum ulcer    | <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> lower back pain    | <input type="checkbox"/> Rapid Heart Rate     | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> brain cancer    | <input type="checkbox"/> Emphysema         | <input type="checkbox"/> hypertension           | <input type="checkbox"/> lung cancer        | <input type="checkbox"/> rectum cancer        | <input type="checkbox"/> Ulcer                |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> hyperthyroidism        | <input type="checkbox"/> Lung Disease       | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> upper back pain      |
| <input type="checkbox"/> breast cancer   | <input type="checkbox"/> esophageal cancer | <input type="checkbox"/> hypotension            | <input type="checkbox"/> migrane            | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Vaginal Discharge    |
| <input type="checkbox"/> Bulemia         | <input type="checkbox"/> Fainting          | <input type="checkbox"/> hypothyroidism         | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scoliosis            | <input type="checkbox"/> _____                |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> gouty arthritis   | <input type="checkbox"/> Irregular Bowel Habits | <input type="checkbox"/> neck pain          | <input type="checkbox"/> shoulder pain        | <input type="checkbox"/> _____                |
| <input type="checkbox"/> chest pain      | <input type="checkbox"/> Hay Fever         | <input type="checkbox"/> Irregular Menstrual    | <input type="checkbox"/> osteo arthritis    | <input type="checkbox"/> Sickle Cell Anemia   | <input type="checkbox"/> _____                |

Select all choices that apply to the patient's family (please do not include relations by marriage).

- |  |  |   |   |   |   |
|--|--|---|---|---|---|
| <input type="checkbox"/> Abdominal Pain  | <input type="checkbox"/> Colitis           | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Irritable Colon    | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Sinus Trouble        |
| <input type="checkbox"/> Allergies       | <input type="checkbox"/> colon cancer      | <input type="checkbox"/> Heart Attacks          | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Painful Urination    | <input type="checkbox"/> Spinal Disc Disorder |
| <input type="checkbox"/> Angina          | <input type="checkbox"/> Convulsions       | <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Kidney Stones      | <input type="checkbox"/> peptic ulcer         | <input type="checkbox"/> STDs                 |
| <input type="checkbox"/> Anorexia        | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> hepatitis A            | <input type="checkbox"/> kyphosis           | <input type="checkbox"/> PMS                  | <input type="checkbox"/> stomach cancer       |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> juvenile diabetes | <input type="checkbox"/> hepatitis B            | <input type="checkbox"/> leg pain           | <input type="checkbox"/> Polio                | <input type="checkbox"/> stomach ulcer        |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> adult diabetes    | <input type="checkbox"/> hepatitis C            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Profuse Menstrual    | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Dislocated Joints | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> lordosis           | <input type="checkbox"/> prostate cancer      | <input type="checkbox"/> Thyroid Disorder     |
| <input type="checkbox"/> Blood Disorder  | <input type="checkbox"/> Dizziness         | <input type="checkbox"/> hip pain               | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> traumatic arthritis  |
| <input type="checkbox"/> Bone Cancer     | <input type="checkbox"/> duodenum ulcer    | <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> lower back pain    | <input type="checkbox"/> Rapid Heart Rate     | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> brain cancer    | <input type="checkbox"/> Emphysema         | <input type="checkbox"/> hypertension           | <input type="checkbox"/> lung cancer        | <input type="checkbox"/> rectum cancer        | <input type="checkbox"/> Ulcer                |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> hyperthyroidism        | <input type="checkbox"/> Lung Disease       | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> upper back pain      |
| <input type="checkbox"/> breast cancer   | <input type="checkbox"/> esophageal cancer | <input type="checkbox"/> hypotension            | <input type="checkbox"/> migrane            | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Vaginal Discharge    |
| <input type="checkbox"/> Bulemia         | <input type="checkbox"/> Fainting          | <input type="checkbox"/> hypothyroidism         | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scoliosis            | <input type="checkbox"/> _____                |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> gouty arthritis   | <input type="checkbox"/> Irregular Bowel Habits | <input type="checkbox"/> neck pain          | <input type="checkbox"/> shoulder pain        | <input type="checkbox"/> _____                |
| <input type="checkbox"/> chest pain      | <input type="checkbox"/> Hay Fever         | <input type="checkbox"/> Irregular Menstrual    | <input type="checkbox"/> osteo arthritis    | <input type="checkbox"/> Sickle Cell Anemia   | <input type="checkbox"/> _____                |

**Patient exercises:**  Moderately  Occasionally  Rarely  Regularly  Never

**Patient smokes:**  2 packs per day  1/2+ pack per day  Never  \_\_\_\_\_  
 2+ packs per day  1 pack per day  1/2 pack a day or less  \_\_\_\_\_

**Patient uses alcohol:**  Excessively  Moderately  Occasionally  Rarely  Never

**Medication the patient is currently taking:**  Muscle Relaxants  No prescription  Psychotropic  \_\_\_\_\_  
 Analgesics  Birth Control  No non-prescription  medications  medication  \_\_\_\_\_  
 Anti-Inflammatory  Hypertension  medication  Tranquilizers  Vitamin supplements  \_\_\_\_\_

**Allergies - please mark all that apply:**  Dust  Penicillan  Pollen  Sulfa Drugs  
 Animal Dander  Dairy Products  Latex  Perfumes  Secondary Smoke  No known allergies

**Who is/was your most recent general physician?** \_\_\_\_\_

**What was his/her diagnosis?** \_\_\_\_\_

**Who was your last Doctor?** \_\_\_\_\_

**What were his/her findings?** \_\_\_\_\_

**Please list any previous injuries and/or accidents with approximate dates:** \_\_\_\_\_

**Past Surgical History (inlcude date, location, surgeon's name, the type of surgery, and list complications)**

\_\_\_\_\_

**Past Hospitalizations (date, complications, and cause of hospitalization)**

\_\_\_\_\_

**History of Pregnancy** \_\_\_\_\_

**Treatment and Diagnostic**

<input type="checkbox"/> Plain X-Rays	Date _____	Location _____	Results _____
<input type="checkbox"/> CT Scan	Date _____	Location _____	Results _____
<input type="checkbox"/> MRI	Date _____	Location _____	Results _____
<input type="checkbox"/> EMG	Date _____	Location _____	Results _____
<input type="checkbox"/> Thermogram	Date _____	Location _____	Results _____
<input type="checkbox"/> Bone Scan	Date _____	Location _____	Results _____
<input type="checkbox"/> Discogram	Date _____	Location _____	Results _____
<input type="checkbox"/> Myelogram	Date _____	Location _____	Results _____
<input type="checkbox"/> Nerve Block Injection	<input type="checkbox"/> Facett Injection	<input type="checkbox"/> Bioelectric Treatment	<input type="checkbox"/> Other _____
<input type="checkbox"/> Trigger Point Injection	<input type="checkbox"/> Tendon Sheath Injection	<input type="checkbox"/> EMG Needle Exam	<input type="checkbox"/> Other _____
<input type="checkbox"/> Joint Injection	<input type="checkbox"/> Botox Injection	<input type="checkbox"/> Spinal Infusion Pump	<input type="checkbox"/> Other _____
<input type="checkbox"/> Epidural Injection	<input type="checkbox"/> IV	<input type="checkbox"/> Spinal Cord Stimulator	

**Social History Rev.**

<b>Marital Status?</b> <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<b>How often do you eat a well-balanced diet?</b> <input type="checkbox"/> never <input type="checkbox"/> rarely <input type="checkbox"/> occasionally <input type="checkbox"/> usually <input type="checkbox"/> always	<b>How often do you exercise?</b> <input type="checkbox"/> never <input type="checkbox"/> rarely <input type="checkbox"/> occasionally <input type="checkbox"/> regularly	<b>Have you traveled internationally?</b> <input type="checkbox"/> never <input type="checkbox"/> recently <input type="checkbox"/> occasionally <input type="checkbox"/> in the past	<b>Recreational Drug Use? (optional)</b> <input type="checkbox"/> never <input type="checkbox"/> occasionally <input type="checkbox"/> often <input type="checkbox"/> in the past	<b>Hours of Sleep per night?</b> <input type="checkbox"/> 1 hour <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 5 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 7 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> 9 hours <input type="checkbox"/> 10 or more
<b>Years of Education?</b> <input type="checkbox"/> Less than 10 <input type="checkbox"/> 10 years <input type="checkbox"/> 11 years <input type="checkbox"/> 12 years <input type="checkbox"/> 13 years <input type="checkbox"/> 14 years <input type="checkbox"/> 15 years <input type="checkbox"/> 16 years <input type="checkbox"/> more than 16	<b>How often do you drink beverages with caffeine?</b> <input type="checkbox"/> never <input type="checkbox"/> less than 1 caffeinated beverage per day <input type="checkbox"/> 1-2 caffeinated beverages per day <input type="checkbox"/> 2-3 caffeinated beverages per day <input type="checkbox"/> 3-4 caffeinated beverages per day <input type="checkbox"/> 4-5 caffeinated beverages per day	<b>Hand of Dominance</b> <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> amidextros			

**Occupational History**

**What limitations have you experienced as a result of your injury? (choose all that apply)**

<input type="checkbox"/> Cannot use left arm	<input type="checkbox"/> Increased fatigability	<input type="checkbox"/> Unable to lift more than 15 pounds	<input type="checkbox"/> _____
<input type="checkbox"/> Cannot use right arm	<input type="checkbox"/> Lifting exacerbates condition	<input type="checkbox"/> Unable to lift more than 20 pounds	<input type="checkbox"/> _____
<input type="checkbox"/> Cannot use left leg	<input type="checkbox"/> Pain limits amount of movement	<input type="checkbox"/> Unable to lift more than 25 pounds	<input type="checkbox"/> _____
<input type="checkbox"/> Cannot use right leg	<input type="checkbox"/> Cannot sit due to condition	<input type="checkbox"/> Unable to lift more than 50 pounds	<input type="checkbox"/> _____
<input type="checkbox"/> Cannot drive due to condition	<input type="checkbox"/> Unable to lift more than 10 pounds	<input type="checkbox"/> Cannot walk due to condition	<input type="checkbox"/> _____

**Your present job involves:**

<b>Standing for:</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hour <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> > 8 hours	<b>Driving for:</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hour <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> > 8 hours	<b>Walking for:</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hour <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> > 8 hours	<b>Sitting for:</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hour <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> > 8 hours	<b>Lifting (pre-injury)</b> <input type="checkbox"/> Less than 5 lbs. <input type="checkbox"/> 05 - 10 lbs. <input type="checkbox"/> 10 - 15 lbs. <input type="checkbox"/> 15 - 20 lbs. <input type="checkbox"/> 20 - 25 lbs. <input type="checkbox"/> 25 - 40 lbs. <input type="checkbox"/> 40 - 50 lbs. <input type="checkbox"/> > 50 lbs.	<b>Lifting (post-injury)</b> <input type="checkbox"/> Less than 5 lbs. <input type="checkbox"/> 05 - 10 lbs. <input type="checkbox"/> 10 - 15 lbs. <input type="checkbox"/> 15 - 20 lbs. <input type="checkbox"/> 20 - 25 lbs. <input type="checkbox"/> 25 - 40 lbs. <input type="checkbox"/> 40 - 50 lbs. <input type="checkbox"/> > 50 lbs.
<b>Typing</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hour <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> > 8 hours	<b>Using Mouse</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hour <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> > 8 hours	<b>Grasping</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hour <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> > 8 hours	<b>Crawling</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hour <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> > 8 hours	<b>Climbing</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hour <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> > 8 hours	<input type="checkbox"/> <b>Repetitive Motion</b>  <input type="checkbox"/> <b>Fine manipulation, pushing, pulling, torquing with hands</b>

**Have you missed any work as a result of your condition?**

Yes  No

**If yes, how many days did you miss?** \_\_\_\_\_

**Your last full day of work was:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Are you currently receiving worker's compensation?**

Yes  No

**Have you had any prior work injuries?**

Yes  No

**Have you received a prior workers' comp award?**

Yes  No

# Review of Systems Rev. (Page 1 of 3)

All Systems Checked were Normal with no past or present symptomatology.

## HEART & VASCULAR Do you have or have you had... ? WNL-No Heart & Vascular complaints.

current/past <input type="checkbox"/> <input type="checkbox"/> have an <b>unusually slow pulse</b> <input type="checkbox"/> <input type="checkbox"/> get <b>Pain over Heart or Angina**</b> <input type="checkbox"/> <input type="checkbox"/> Have you been treated for <b>Blood Clots**?</b> <input type="checkbox"/> <input type="checkbox"/> <b>Hands or Feet turn Blue</b> <input type="checkbox"/> <input type="checkbox"/> <b>Hands or Feet get cold</b> easily	current/past <input type="checkbox"/> <input type="checkbox"/> feel <b>Light Headed</b> when standing quickly <input type="checkbox"/> <input type="checkbox"/> have a <b>Heart Murmur</b> <input type="checkbox"/> <input type="checkbox"/> have a history of <b>Heart problems**</b> <input type="checkbox"/> <input type="checkbox"/> have <b>High blood pressure</b> <input type="checkbox"/> <input type="checkbox"/> get <b>Leg Pain</b> walking short distances <input type="checkbox"/> <input type="checkbox"/> have unusually <b>Low blood pressure</b>	current/past <input type="checkbox"/> <input type="checkbox"/> <b>Heart Skip Beats?</b> <input type="checkbox"/> <input type="checkbox"/> get a <b>Rapid heartbeat</b> easily <input type="checkbox"/> <input type="checkbox"/> have or get <b>Sores** that Don't Heal</b> <input type="checkbox"/> <input type="checkbox"/> Are your <b>Ankles Frequently Swollen?</b> <input type="checkbox"/> <input type="checkbox"/> <b>take Nitroglycerine</b> <input type="checkbox"/> <input type="checkbox"/> suffer from <b>Varicose veins</b>
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## MUSCULOSKELETAL Do you have or have you had....? WNL-No Musculoskeletal complaints.

current/past <input type="checkbox"/> <input type="checkbox"/> <b>Back Injuries</b> <input type="checkbox"/> <input type="checkbox"/> <b>Back pain</b> <input type="checkbox"/> <input type="checkbox"/> <b>Neck Pain</b> <input type="checkbox"/> <input type="checkbox"/> <b>Heel Spurs</b> <input type="checkbox"/> <input type="checkbox"/> <b>Hot joints</b> <input type="checkbox"/> <input type="checkbox"/> <b>Joint pain</b> <input type="checkbox"/> <input type="checkbox"/> <b>Joint stiffness</b>	current/past <input type="checkbox"/> <input type="checkbox"/> <b>Joint swelling</b> <input type="checkbox"/> <input type="checkbox"/> <b>Neck Injuries</b> <input type="checkbox"/> <input type="checkbox"/> <b>Painful Feet</b> <input type="checkbox"/> <input type="checkbox"/> <b>Rheumatism</b> <input type="checkbox"/> <input type="checkbox"/> <b>Muscle cramps</b> <input type="checkbox"/> <input type="checkbox"/> <b>Muscle pain</b>	current/past <input type="checkbox"/> <input type="checkbox"/> <b>Muscle Tenderness</b> <input type="checkbox"/> <input type="checkbox"/> <b>Muscle twitching</b> <input type="checkbox"/> <input type="checkbox"/> <b>Muscle weakness</b> <input type="checkbox"/> <input type="checkbox"/> <b>Leg Cramps</b> during the day <input type="checkbox"/> <input type="checkbox"/> <b>Leg cramps</b> while in bed or at rest <input type="checkbox"/> <input type="checkbox"/> <b>Osteoarthritis</b>	current/past <input type="checkbox"/> <input type="checkbox"/> <b>Pain Between the Shoulders</b> <input type="checkbox"/> <input type="checkbox"/> <b>Frequent Foot Cramps</b> <input type="checkbox"/> <input type="checkbox"/> <b>General Muscle Tension</b> <input type="checkbox"/> <input type="checkbox"/> <b>Shoulder / Arm Pain</b> <input type="checkbox"/> <input type="checkbox"/> <b>Spinal curvature**</b> (scoliosis) <input type="checkbox"/> <input type="checkbox"/> <b>Tenderness over a Rib**?</b> <input type="checkbox"/> <input type="checkbox"/> <b>Tenderness over a Bone**?</b>
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## RESPIRATORY Do you have or have you had....? WNL-No Respiratory complaints.

current/past <input type="checkbox"/> <input type="checkbox"/> have a <b>Chronic Chest Condition**?</b> <input type="checkbox"/> <input type="checkbox"/> Have you been <b>Exposed to Asbestos?</b> <input type="checkbox"/> <input type="checkbox"/> have <b>Asthma?</b> <input type="checkbox"/> <input type="checkbox"/> have a <b>Chronic Cough?</b> <input type="checkbox"/> <input type="checkbox"/> suffer from <b>Congestion?</b> <input type="checkbox"/> <input type="checkbox"/> ever <b>Cough up Blood**?</b>	current/past <input type="checkbox"/> <input type="checkbox"/> experience <b>Difficulty Breathing?</b> <input type="checkbox"/> <input type="checkbox"/> have <b>Hay Fever?</b> <input type="checkbox"/> <input type="checkbox"/> have a <b>Dry Cough?</b> <input type="checkbox"/> <input type="checkbox"/> experience <b>Pain upon breathing?</b> <input type="checkbox"/> <input type="checkbox"/> have <b>Pain upon expiration?</b> <input type="checkbox"/> <input type="checkbox"/> have <b>Pain upon inspiration?</b>	current/past <input type="checkbox"/> <input type="checkbox"/> experience excessive <b>Phlegm?</b> <input type="checkbox"/> <input type="checkbox"/> have a <b>Productive Cough?</b> <input type="checkbox"/> <input type="checkbox"/> Catch <b>Severe Colds?</b> <input type="checkbox"/> <input type="checkbox"/> get <b>Short of Breath?</b> <input type="checkbox"/> <input type="checkbox"/> experience <b>Wheezing?</b>
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## NEUROMUSCULAR Do you or Have you ever ...? WNL-No complaints for Neuromuscular.

current/past <input type="checkbox"/> <input type="checkbox"/> experience <b>Confusion?</b> <input type="checkbox"/> <input type="checkbox"/> have <b>Convulsions?</b> <input type="checkbox"/> <input type="checkbox"/> experience <b>Difficulty of speech?</b> <input type="checkbox"/> <input type="checkbox"/> ever feel a sense of <b>Dizziness/Vertigo?</b> <input type="checkbox"/> <input type="checkbox"/> ever experience <b>Double Vision?</b> <input type="checkbox"/> <input type="checkbox"/> had a history of <b>Fainting?</b> <input type="checkbox"/> <input type="checkbox"/> find yourself in a state of <b>Forgetfulness?</b>	current/past <input type="checkbox"/> <input type="checkbox"/> your <b>Hands Tremble?</b> <input type="checkbox"/> <input type="checkbox"/> get frequent <b>Headaches?</b> <input type="checkbox"/> <input type="checkbox"/> have <b>Incoordination</b> of movement? <input type="checkbox"/> <input type="checkbox"/> had a <b>Loss of Consciousness?</b> <input type="checkbox"/> <input type="checkbox"/> Is there any <b>Loss of Feeling**</b> anywhere? <input type="checkbox"/> <input type="checkbox"/> noticed having <b>Loss of Memory?</b> <input type="checkbox"/> <input type="checkbox"/> Have you ever had <b>Meningitis?</b>	current/past <input type="checkbox"/> <input type="checkbox"/> get <b>Muscle Jerking or Twitching**?</b> <input type="checkbox"/> <input type="checkbox"/> Is there <b>Numbness or Tingling**</b> anywhere? <input type="checkbox"/> <input type="checkbox"/> suffered any type of <b>Paralysis?</b> <input type="checkbox"/> <input type="checkbox"/> had <b>Seizures?</b> <input type="checkbox"/> <input type="checkbox"/> <b>Stutter?</b> <input type="checkbox"/> <input type="checkbox"/> have an unusually <b>Weak Grip?</b>
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\*\* Please include details: where, when, how often, dates, etc.

**Notes:**

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## EAR, NOSE & THROAT Do You...? WNL-No complaints for ENT.

current/past <input type="checkbox"/> <input type="checkbox"/> have a <b>Loss of Smell (Anosmia)?</b> <input type="checkbox"/> <input type="checkbox"/> get <b>Bleeding Gums?</b> <input type="checkbox"/> <input type="checkbox"/> get <b>Blisters or Cold Sores</b> of the Mouth? <input type="checkbox"/> <input type="checkbox"/> have <b>Toothaches or Dental problems?</b> <input type="checkbox"/> <input type="checkbox"/> have a <b>Deviated Septum?</b> <input type="checkbox"/> <input type="checkbox"/> have a <b>Dry Mouth?</b> <input type="checkbox"/> <input type="checkbox"/> have <b>Trouble Swallowing**</b> (Dysphagia)? <input type="checkbox"/> <input type="checkbox"/> have <b>Discharge from the Ear?</b> <input type="checkbox"/> <input type="checkbox"/> experience <b>Ear noises or Ringing?</b> <input type="checkbox"/> <input type="checkbox"/> experience frequent <b>Ear pain**?</b> <input type="checkbox"/> <input type="checkbox"/> have <b>Excessive Saliva?</b> <input type="checkbox"/> <input type="checkbox"/> have <b>Frequent Colds?</b>	current/past <input type="checkbox"/> <input type="checkbox"/> Are your <b>Gums ever Sore?</b> <input type="checkbox"/> <input type="checkbox"/> have <b>Bad Breath (Halitosis)?</b> <input type="checkbox"/> <input type="checkbox"/> have any <b>Hearing loss?</b> <input type="checkbox"/> <input type="checkbox"/> have <b>Missing Teeth or wear Dentures**?</b> <input type="checkbox"/> <input type="checkbox"/> suffer from <b>Motion Sickness?</b> <input type="checkbox"/> <input type="checkbox"/> have <b>Nasal Breathing problems?</b> <input type="checkbox"/> <input type="checkbox"/> suffer <b>Post Nasal Drip?</b> <input type="checkbox"/> <input type="checkbox"/> have <b>Nasal Polyps?</b> <input type="checkbox"/> <input type="checkbox"/> get <b>Nose bleeds**?</b> <input type="checkbox"/> <input type="checkbox"/> Constantly have a <b>Nose Run ?</b> <input type="checkbox"/> <input type="checkbox"/> have a <b>Punctured Ear Drum?</b> <input type="checkbox"/> <input type="checkbox"/> suffer from <b>recurrent Ear infections?</b>	current/past <input type="checkbox"/> <input type="checkbox"/> get frequent <b>Sinus Infections?</b> <input type="checkbox"/> <input type="checkbox"/> have <b>Sinus Pain?</b> <input type="checkbox"/> <input type="checkbox"/> have <b>Sneezing Spells?</b> <input type="checkbox"/> <input type="checkbox"/> frequently have a <b>Sore or Hoarse throat?</b> <input type="checkbox"/> <input type="checkbox"/> frequently have a <b>Sore Tongue?</b> <input type="checkbox"/> <input type="checkbox"/> get <b>Sores or Cracks at mouth corners?</b> <input type="checkbox"/> <input type="checkbox"/> frequently experience <b>canker sores?</b> <input type="checkbox"/> <input type="checkbox"/> often have swollen <b>Glands**?</b> <input type="checkbox"/> <input type="checkbox"/> have a badly coated <b>Tongue ?</b> <input type="checkbox"/> <input type="checkbox"/> get <b>Tonsillitis**</b> often? <input type="checkbox"/> <input type="checkbox"/> ever get <b>Vertigo or Dizziness**?</b>
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# Review of Systems Rev. (Page 2 of 3)

## EYES WNL-No complaints for Eyes.

current/past	current/past	current/past
<input type="checkbox"/> <input type="checkbox"/> Do your eyes have a <b>Burning Sensation</b> ?	<input type="checkbox"/> <input type="checkbox"/> Are your eyes <b>Dry</b> or feel <b>gritty</b> ?	<input type="checkbox"/> <input type="checkbox"/> Are you <b>Near Sighted</b> (Can't see Far)?
<input type="checkbox"/> <input type="checkbox"/> Have you had an <b>Injury**</b> to the eyes?	<input type="checkbox"/> <input type="checkbox"/> Are you <b>Far Sighted</b> (Can't see Near)?	<input type="checkbox"/> <input type="checkbox"/> Do you have <b>Redness</b> of the eyes?
<input type="checkbox"/> <input type="checkbox"/> Is your <b>Vision Blurred</b> ?	<input type="checkbox"/> <input type="checkbox"/> Can you see/feel <b>Heart Beat**</b> in the eyes?	<input type="checkbox"/> <input type="checkbox"/> Do you have <b>Swelling</b> of the eyes?
<input type="checkbox"/> <input type="checkbox"/> Do you have <b>Cataracts</b> ?	<input type="checkbox"/> <input type="checkbox"/> Do you have <b>Glaucoma</b> ?	<input type="checkbox"/> <input type="checkbox"/> Is there <b>Tearing, Crusting or Discharge</b> ?
<input type="checkbox"/> <input type="checkbox"/> Do you suffer from <b>Crossed Eyes</b> ?	<input type="checkbox"/> <input type="checkbox"/> Are your eyes <b>Itchy</b> ?	<input type="checkbox"/> <input type="checkbox"/> Do you get <b>Vision Headaches**</b> ?

## INTEGUMENT (skin, hair, nails) WNL-No complaints for Integument.

current/past	current/past	current/past
<input type="checkbox"/> <input type="checkbox"/> <b>Moles with changes in color or size**</b> ?	<input type="checkbox"/> <input type="checkbox"/> Do you have <b>Dandruff</b> ?	<input type="checkbox"/> <input type="checkbox"/> Does your <b>skin or scalp Itch</b> ?
<input type="checkbox"/> <input type="checkbox"/> Do you get <b>Acne</b> ?	<input type="checkbox"/> <input type="checkbox"/> Is your skin especially <b>Dry</b> ?	<input type="checkbox"/> <input type="checkbox"/> noticed any <b>Nail Bed Changes</b> ?
<input type="checkbox"/> <input type="checkbox"/> Do you get <b>Boils</b> ?	<input type="checkbox"/> <input type="checkbox"/> Do you have <b>Eczema</b> ?	<input type="checkbox"/> <input type="checkbox"/> Have you ever had a <b>Nail Fungus</b> ?
<input type="checkbox"/> <input type="checkbox"/> Do you <b>Bruise Easily</b> ?	<input type="checkbox"/> <input type="checkbox"/> have <b>Excessive Perspiration</b> ?	<input type="checkbox"/> <input type="checkbox"/> Do you have <b>Plantar Warts</b> ?
<input type="checkbox"/> <input type="checkbox"/> Are you troubled with <b>Corns</b> ?	<input type="checkbox"/> <input type="checkbox"/> noted <b>Hair changes anywhere</b> ?	<input type="checkbox"/> <input type="checkbox"/> Do you have <b>Psoriasis</b> ?
<input type="checkbox"/> <input type="checkbox"/> Is your skin <b>Coarse</b> or have <b>Small bumps</b> ?	<input type="checkbox"/> <input type="checkbox"/> Do you ever get <b>Hives**</b> ?	<input type="checkbox"/> <input type="checkbox"/> Do you experience <b>Rashes**</b> often?
		<input type="checkbox"/> <input type="checkbox"/> Do you get <b>Sores**</b> often?

## ALLERGIES No Allergies. **\*\* Please include details: where, when, how often, dates, etc.**

Which of the following are you allergic to:			<b>Notes:</b>     
current/past	current/past		
<input type="checkbox"/> <input type="checkbox"/> Animal dander	<input type="checkbox"/> <input type="checkbox"/> Exhaust Fumes	<input type="checkbox"/> <input type="checkbox"/> Perfumes	
<input type="checkbox"/> <input type="checkbox"/> Food allergies	<input type="checkbox"/> <input type="checkbox"/> Grasses	<input type="checkbox"/> <input type="checkbox"/> Pollen	
<input type="checkbox"/> <input type="checkbox"/> Chemicals	<input type="checkbox"/> <input type="checkbox"/> Hay	<input type="checkbox"/> <input type="checkbox"/> Potpourri	
<input type="checkbox"/> <input type="checkbox"/> Dairy	<input type="checkbox"/> <input type="checkbox"/> Mold	<input type="checkbox"/> <input type="checkbox"/> Smoke	
<input type="checkbox"/> <input type="checkbox"/> Dust	<input type="checkbox"/> <input type="checkbox"/> Paint		

## GASTRO-INTESTINAL Do You...? WNL-No Gastro-Intestinal Complaints.

current/past		
<input type="checkbox"/> <input type="checkbox"/> have <b>Abdominal Gas</b> ?	<input type="checkbox"/> <input type="checkbox"/> suffer <b>frequent Indigestion</b> ?	<input type="checkbox"/> <input type="checkbox"/> get <b>Nauseous</b> easily?
<input type="checkbox"/> <input type="checkbox"/> have severe <b>Abdominal pain</b> ?	<input type="checkbox"/> <input type="checkbox"/> <b>Vomit Food</b> frequently**?	<input type="checkbox"/> <input type="checkbox"/> use <b>Laxatives or Stool Softeners</b> ?
<input type="checkbox"/> <input type="checkbox"/> experience <b>Acid Reflux**</b> ?	<input type="checkbox"/> <input type="checkbox"/> have <b>Gallbladder Disease</b> ?	<input type="checkbox"/> <input type="checkbox"/> get <b>Pain or Indigestion</b> from Greasy Food?
<input type="checkbox"/> <input type="checkbox"/> <b>Belch or Burp</b> after eating?	<input type="checkbox"/> <input type="checkbox"/> have 1 or less <b>Bowel Movements</b> per day?	<input type="checkbox"/> <input type="checkbox"/> have <b>Pale or Yellow Stools</b> ?
<input type="checkbox"/> <input type="checkbox"/> ever have <b>Black or Bloody stools</b> ?	<input type="checkbox"/> <input type="checkbox"/> experience <b>Heart Burn</b> ?	<input type="checkbox"/> <input type="checkbox"/> have <b>Stomach Ulcers</b> ?
<input type="checkbox"/> <input type="checkbox"/> have frequent <b>Constipation</b> ?	<input type="checkbox"/> <input type="checkbox"/> suffer from <b>Hemorrhoids</b> ?	<input type="checkbox"/> <input type="checkbox"/> frequently <b>Strain</b> during bowel movements?
<input type="checkbox"/> <input type="checkbox"/> have loose BM's or <b>Diarrhea</b> ?	<input type="checkbox"/> <input type="checkbox"/> Ever had <b>Intestinal Worms</b> ?	<input type="checkbox"/> <input type="checkbox"/> ever <b>Vomit Blood**</b> ?
<input type="checkbox"/> <input type="checkbox"/> have <b>Difficulty Swallowing**</b> ?	<input type="checkbox"/> <input type="checkbox"/> have <b>Liver Disease**</b> ?	

## GYNECOLOGICAL Do You...? WNL-No Gynecological complaints.

current/past	current/past	current/past
<input type="checkbox"/> <input type="checkbox"/> take <b>Birth Control</b> Pills or Injections**?	<input type="checkbox"/> <input type="checkbox"/> have <b>Hot Flashes</b> ?	<input type="checkbox"/> <input type="checkbox"/> have <b>Lumps in your Breasts**</b> ?
<input type="checkbox"/> <input type="checkbox"/> have <b>Chronic Yeast Infections**</b> ?	<input type="checkbox"/> <input type="checkbox"/> get <b>Acne</b> worse during your periods?	<input type="checkbox"/> <input type="checkbox"/> have <b>Poor or Infrequent Orgasms</b> ?
<input type="checkbox"/> <input type="checkbox"/> have <b>Deminshed Sexual Desires</b> ?	<input type="checkbox"/> <input type="checkbox"/> Are your <b>Periods Irregular</b> ?	<input type="checkbox"/> <input type="checkbox"/> have <b>Pre-Menstrual Depression</b> ?
<input type="checkbox"/> <input type="checkbox"/> <b>Retain Fluid</b> during your periods?	<input type="checkbox"/> <input type="checkbox"/> Have you reached <b>Menopause</b> ?	<input type="checkbox"/> <input type="checkbox"/> have <b>Spotting</b> between periods?
<input type="checkbox"/> <input type="checkbox"/> have unusually <b>Heavy Menstrual Flow</b> ?	<input type="checkbox"/> <input type="checkbox"/> have Painful Periods or <b>Mentsral Cramps</b> ?	<input type="checkbox"/> <input type="checkbox"/> have <b>Tender Breasts</b> ?
<input type="checkbox"/> <input type="checkbox"/> have <b>Heavy Hair Growth</b> on Face or Body?	<input type="checkbox"/> <input type="checkbox"/> Is <b>Intercourse</b> Painful?	<b>Date of Last Menstrual Period:</b>

## GENERAL GENITO-URINARY Do You...? WNL-No Genito-Urinary complaints.

current/past	current/past	current/past
<input type="checkbox"/> <input type="checkbox"/> have a <b>Discharge</b> other than urine?	<input type="checkbox"/> <input type="checkbox"/> have difficulty <b>Starting a Stream</b> ?	<input type="checkbox"/> <input type="checkbox"/> get <b>Kidney or Bladder Infections</b> ?
<input type="checkbox"/> <input type="checkbox"/> have non-muscular <b>Back Pain**</b> ?	<input type="checkbox"/> <input type="checkbox"/> have <b>Discolored</b> urine Brown, Red, etc?	<input type="checkbox"/> <input type="checkbox"/> have a history of <b>Kidney Stones**</b> ?
<input type="checkbox"/> <input type="checkbox"/> experience <b>Bed Wetting**</b> ?	<input type="checkbox"/> <input type="checkbox"/> experience <b>Dribbling</b> of your urine?	<input type="checkbox"/> <input type="checkbox"/> have <b>Painful Urination</b> ?
<input type="checkbox"/> <input type="checkbox"/> ever have <b>Bladder Control Problems</b> ?	<input type="checkbox"/> <input type="checkbox"/> have <b>Frequent Urination**</b> ?	<input type="checkbox"/> <input type="checkbox"/> have <b>Scanty Urination</b> ?
<input type="checkbox"/> <input type="checkbox"/> experience <b>Burning</b> during unriation?	<input type="checkbox"/> <input type="checkbox"/> <b>Awaken at Night</b> to urinate**?	<input type="checkbox"/> <input type="checkbox"/> experience <b>Urgency</b> to urinate?
<input type="checkbox"/> <input type="checkbox"/> have <b>Cloudy or Foul Smelling urine</b> ?	<input type="checkbox"/> <input type="checkbox"/> urine have a <b>Small Caliber Stream</b> ?	

## MALE GENITO-URINARY WNL-No Complaints for Male Repro. **Please include details: where, when, how often, dates, etc.**

current/past	current/past	<b>Notes:</b>     
<input type="checkbox"/> <input type="checkbox"/> have a history of <b>Cancer**</b> ?	<input type="checkbox"/> <input type="checkbox"/> have <b>Lumps in your Testicles**</b> ?	
<input type="checkbox"/> <input type="checkbox"/> have <b>Difficulty Completing Intercourse</b> ?	<input type="checkbox"/> <input type="checkbox"/> have <b>Painful Genitals</b> ?	
<input type="checkbox"/> <input type="checkbox"/> Have <b>Difficulty Conceiving Children</b> ?	<input type="checkbox"/> <input type="checkbox"/> have <b>Prostate Hypertrophy**</b> ?	
<input type="checkbox"/> <input type="checkbox"/> Are you <b>Impotent</b> ?	<input type="checkbox"/> <input type="checkbox"/> have <b>Sores on External Genitalia</b> ?	
<input type="checkbox"/> <input type="checkbox"/> Have you had any <b>Hernias**</b> ?	<input type="checkbox"/> <input type="checkbox"/> have any <b>Tender Lymph Nodes**</b> ?	
<input type="checkbox"/> <input type="checkbox"/> have an <b>Erection</b> every morning/	<input type="checkbox"/> <input type="checkbox"/> take anabolic type <b>Steroids**</b> ?	

# Review of Systems Rev. (Page 3 of 3)

ENDOCRINE		Do You / Are You...?	<input type="checkbox"/> WNL-Endocrine has none
current/past <input type="checkbox"/> <input type="checkbox"/> experiencing <b>Loss of Appetite</b> ? <input type="checkbox"/> <input type="checkbox"/> unusually <b>Tired Most of the Time</b> ? <input type="checkbox"/> <input type="checkbox"/> unusually <b>Jumpy or Nervous</b> ? <input type="checkbox"/> <input type="checkbox"/> noticing any <b>Hair changes**</b> ? <input type="checkbox"/> <input type="checkbox"/> <b>Intolerant to cold</b> ? <input type="checkbox"/> <input type="checkbox"/> have <b>Excessive Hunger</b> ?	current/past <input type="checkbox"/> <input type="checkbox"/> have <b>Excessive Thirst</b> ? <input type="checkbox"/> <input type="checkbox"/> suffer <b>Extreme thinness**</b> ? <input type="checkbox"/> <input type="checkbox"/> extremely <b>Drowsy after Eating</b> ? <input type="checkbox"/> <input type="checkbox"/> feel generally <b>Weak</b> ? <input type="checkbox"/> <input type="checkbox"/> <b>Shaky or Faint when Hungry</b> ? <input type="checkbox"/> <input type="checkbox"/> have <b>Diabetes**</b> ?	current/past <input type="checkbox"/> <input type="checkbox"/> <b>Intolerant to heat</b> ? <input type="checkbox"/> <input type="checkbox"/> noticing an increasingly <b>Hoarse voice</b> ? <input type="checkbox"/> <input type="checkbox"/> notice that <b>Eating Relieve Fatigue</b> ? <input type="checkbox"/> <input type="checkbox"/> noticing any unexplained <b>Weight gain**</b> ? <input type="checkbox"/> <input type="checkbox"/> noticing any unexplained <b>Weight Loss**</b> ?	

CONSTITUTIONAL		Do You / Are You...?	<input type="checkbox"/> WNL-Constitutional has none
current/past <input type="checkbox"/> <input type="checkbox"/> Any <b>Accidents or Injuries</b> ? (current = last 2 mo) <input type="checkbox"/> <input type="checkbox"/> Do you get <b>Chills</b> ? <input type="checkbox"/> <input type="checkbox"/> Are you having trouble <b>Concentration</b> ? <input type="checkbox"/> <input type="checkbox"/> Any <b>Difficulty Sleeping</b> ? <input type="checkbox"/> <input type="checkbox"/> Are you suffering any <b>Dizzy spells</b> ?	current/past <input type="checkbox"/> <input type="checkbox"/> Any recent <b>Fainting</b> ? <input type="checkbox"/> <input type="checkbox"/> Do you feel <b>Fatigued</b> ? <input type="checkbox"/> <input type="checkbox"/> Do you have a <b>Fever</b> ? <input type="checkbox"/> <input type="checkbox"/> Are you having trouble with <b>Memory</b> ? <input type="checkbox"/> <input type="checkbox"/> Do you feel <b>Nauseated</b> ?	current/past <input type="checkbox"/> <input type="checkbox"/> Are you generally <b>Nervous</b> ? <input type="checkbox"/> <input type="checkbox"/> Do you get " <b>Night Sweats</b> "? <input type="checkbox"/> <input type="checkbox"/> Have you had recent <b>Weight Change**</b> ? <input type="checkbox"/> <input type="checkbox"/> Any noted <b>Side Effects</b> from medications**? <input type="checkbox"/> <input type="checkbox"/> Do you feel <b>Weakness anywhere</b> ?	

BEHAVIORAL/PSYCH		Do You / Have You...?	<input type="checkbox"/> WNL-No complaints for Psych/Behav.
current/past <input type="checkbox"/> <input type="checkbox"/> suffer from <b>Alcoholism</b> ? <input type="checkbox"/> <input type="checkbox"/> frequently become <b>Scared for no reason</b> ? <input type="checkbox"/> <input type="checkbox"/> Are you <b>Timid or Shy</b> ? <input type="checkbox"/> <input type="checkbox"/> been under considerable <b>Emotional Stress</b> ? <input type="checkbox"/> <input type="checkbox"/> Are your Feelings Easily Hurt / <b>Cry Often</b> ? <input type="checkbox"/> <input type="checkbox"/> Are you usually <b>Unhappy or Depressed</b> ? <input type="checkbox"/> <input type="checkbox"/> Any <b>Drug Addictions / Dependencies**</b> ?	current/past <input type="checkbox"/> <input type="checkbox"/> Are you frequently <b>Nervous</b> ? <input type="checkbox"/> <input type="checkbox"/> find yourself in <b>Extreme Worry</b> ? <input type="checkbox"/> <input type="checkbox"/> Are you easily <b>Angered or Irritable</b> ? <input type="checkbox"/> <input type="checkbox"/> Are you frequently <b>Miserable or Blue</b> ? <input type="checkbox"/> <input type="checkbox"/> ever <b>Hyperventilate**</b> ? <input type="checkbox"/> <input type="checkbox"/> ever had <b>Hallucinations</b> ? <input type="checkbox"/> <input type="checkbox"/> always need advise or feel <b>Insecure</b> ?	current/past <input type="checkbox"/> <input type="checkbox"/> <b>Bite your Nails</b> ? <input type="checkbox"/> <input type="checkbox"/> <b>Eat when you are Nervous</b> ? <input type="checkbox"/> <input type="checkbox"/> <b>Fear</b> strangers, being alone, eating out? <input type="checkbox"/> <input type="checkbox"/> suffer <b>Recurrent Bad Dreams**</b> ? <input type="checkbox"/> <input type="checkbox"/> ever " <b>Sleep Walk</b> "**? <input type="checkbox"/> <input type="checkbox"/> ever have <b>Suicidal thoughts**</b> ?	

\*\* Please include details: where, when, how often, dates, etc. \_\_\_\_\_

**Notes:**

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

Date: \_\_\_\_\_

ProHealth & Wellness Chiropractic  
Patient Responsibility Form

Have you filed an injury report with your employer? YES \_\_\_ NO \_\_\_ DATE: \_\_\_\_\_

Carrier: \_\_\_\_\_

Policy # \_\_\_\_\_

Carriers Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Adjuster: \_\_\_\_\_

Claim #: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that ProHealth & Wellness will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly ProHealth & Wellness will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file here they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. If ProHealth & Wellness is required to take any legal action against me to recover any unpaid balance on my account, I agree to reimburse ProHealth & Wellness for the cost of recovery, including reasonable attorney's fee, interest charges, late fees, and collection cost.

Print Patient Name: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Consent to treat a Minor: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse's Signature Authorizing Care \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Print Patient Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Authorization to Release Medical Information

I \_\_\_\_\_ authorize ProHealth & Wellness Chiropractic to release my medical information from their office to the following:

**General Practitioner**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Neurologist**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Internist**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**OB/GYN**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Orthopedist**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Pediatrician**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Other**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_