

Patient Name \_\_\_\_\_ Patient ID# \_\_\_\_\_

If you have ever had a listed symptom in the past, please check that symptom in the *Past Column*. If you are presently troubled by a particular symptom, check that symptom in the *Present Column*. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

- | Past                     | Present                  | Condition   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain   |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain ( R___ ) ( L___ )   |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Arm or Elbow ( R___ ) ( L___ )                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain ( R___ ) ( L___ )   |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain ( R___ ) ( L___ )  |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper Back Pain   |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain   |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in the Upper Leg or Hip( R___ )( L___ )                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in the Lower Leg or Knee( R___ )( L___ )                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in the Ankle or Foot( R___ )( L___ )                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling, Stiffness of Joint(s)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting  |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances   |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions   |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness   |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache  |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular Incoordination   |
| <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus (Ear Noises)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid Heart Beat  |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains   |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite  |
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia  |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight   |
|                          |                          | <input type="checkbox"/> Gain <input type="checkbox"/> Loss             |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst  |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough   |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis   |
| <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue   |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Menstrual Flow  |
| <input type="checkbox"/> | <input type="checkbox"/> | Profuse Menstrual Flow  |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast <input type="checkbox"/> Soreness <input type="checkbox"/> Lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis   |
| <input type="checkbox"/> | <input type="checkbox"/> | PMS   |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control   |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination   |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination  |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation/irregular bowel habits                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in Swallowing  |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/Indigestion   |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash  |

- | Past                     | Present                  | Condition                       |
|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Depression                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm                 |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure             |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack (date)_____        |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date)_____              |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer, Explain _____           |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumor, Explain _____            |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems               |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorder                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema(chronic lung issues)  |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis            |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver/Gallbladder problems      |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection               |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders (by condition) |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable Colon                 |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____                     |

If a family member has had any of the following, please mark the appropriate box:

- |   |  |
|---|--|
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> Chronic Back Problems |
| <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> High Blood Pressure   |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Rheumatoid Arthritis  |
| <input type="checkbox"/> Lupus          | <input type="checkbox"/> Chronic Headaches     |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lung Problems         |
| <input type="checkbox"/> Other _____    |  |

Present Weight \_\_\_\_\_ pounds      Height \_\_\_\_\_ feet \_\_\_\_\_ inches

Yes      No  
       Do you have a permanent disability rating? Location \_\_\_\_\_  
       Date rating received \_\_\_\_/\_\_\_\_/\_\_\_\_  
       Rating Percentage \_\_\_\_\_%

**Please check any of the following that apply to you**

- | Past                     | Present                  | Condition  | Past                     | Present                  | Condition                           |
|--------------------------|--------------------------|--|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # births _____  | <input type="checkbox"/> | <input type="checkbox"/> | Tobacco                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills, type _____  | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Medications (list if not listed elsewhere) _____                             | <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Dependence          |
|                          |                          |  | <input type="checkbox"/> | <input type="checkbox"/> | Coffee/Tea/Caffinated drinks: _____ |
|                          |                          |  |                          |                          | cups/cans perday _____              |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospitalizations/Surgical Procedures (list if not described elsewhere) _____ |                          |                          |                                     |

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages in the future.

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