



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

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

**REVIEW OF SYSTEMS** -Below is a list of symptoms that may seem unrelated to the purpose of your appointment but they must be answered carefully as the problems can affect your overall course of care. Check any that apply to you.

***Constitutional:***

- chills
- fatigue
- night sweats
- weight loss
- daytime drowsiness
- fever
- weight gain

***Eyes/Vision:***

- blindness
- change in vision
- field cuts
- photophobia
- blurred vision
- double vision
- glaucoma
- tearing
- cataracts
- eye pain
- itching
- wear glasses/contacts

***Ears, Nose and Throat:***

- bleeding
- ear drainage
- hearing loss
- nosebleeds
- sore throat
- dentures
- ear pain
- history of head injury
- postnasal drip
- ringing in ears
- hard to swallow
- fainting
- hoarseness
- runny nose
- TMJ problems
- discharge
- frequent sore throats
- loss of sense of smell
- sinus infections
- dizziness
- headaches
- nasal congestion
- snoring

***Respiration:***

- asthma
- coughing up blood
- sputum production
- cough
- shortness of breath
- wheezing

***Cardiovascular:***

- chest pain or discomfort
- high blood pressure
- shortness of breath
- chest pain
- low blood pressure
- swelling of legs
- leg pain/ache
- difficulty breathing lying down
- ulcers
- heart murmur
- palpitations
- varicose veins
- heart problems
- waking at night w/ shortness of breath

***Gastrointestinal:***

- abdominal pain
- diarrhea
- indigestion
- abnormal stool size
- vomiting blood
- belching
- difficulty swallowing
- jaundice
- abnormal stool color
- black - tarry stools
- heartburn
- nausea
- abnormal stool texture
- constipation
- hemorrhoids
- rectal bleeding
- vomiting

***Female:***

- birth control
- cramps
- irregular menstruation
- vaginal bleeding
- breast lumps/pain
- frequent urination
- pregnancy
- vaginal discharge
- burning urination
- hormone therapy
- urine retention

***Male:***

- burning urination
- frequent urination
- prostate problems
- erectile dysfunction
- hesitancy/ dribbling
- urine retention

***Endocrine:***

- cold intolerance
- excessive hunger
- goiter
- unusual hair growth
- diabetes
- excessive thirst
- hair loss
- voice changes
- excessive appetite
- abnormal frequency of urination
- heat intolerance

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**Skin:**

- changes in nail texture
- hair loss
- skin itching
- skin lesions / ulcers
- changes in skin color
- hives
- skin tingling
- varicose veins
- hair growth
- history of skin disorders
- rash

**Nervous System:**

- dizziness
- limb weakness
- numbness
- slurred speech
- tremor
- facial weakness
- loss of consciousness
- seizures
- stress
- unsteadiness of gait/loss of balance
- headache
- loss of memory
- sleep disturbance
- strokes

**Psychologic:**

- loss or change in appetite
- confusion
- insomnia
- memory loss
- anxiety
- bi-polar disorder
- depression
- mood change

**Allergy:**

- trouble breathing
- itching
- chronic nasal congestion
- sneezing
- food intolerance
- acute nasal congestion
- rash

**Hematologic:**

- anemia
- blood clotting
- bruising easily
- lymph node swelling
- bleeding
- blood transfusion
- fatigue

**PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.**

**Previous Care for This Condition:**

Have you seen other doctors for THIS CONDITION?  Yes  No. If yes, Who? (Name) \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Was the treatment helpful?  Yes  No

Explain: \_\_\_\_\_

**Childhood Illness (es): CHECK all CURRENT conditions.**

- ADD
- chicken pox
- headaches
- scoliosis
- atopic dermatitis (eczema)
- crohn's/colitis
- hepatitis
- seizure disorder
- allergies/hayfever
- depression
- HIV
- sickle cell anemia
- anemia
- diabetes
- measles
- spina bifida
- asthma
- ear infections
- mumps
- other:
- bedwetting
- fetal drug exposure
- psoriasis
- cerebral palsy
- food allergies (list below)
- rash

**Adult Illness(es): CHECK all CURRENT conditions.**

- ADD
- cystic kidney disease
- hypertension
- psychiatric problems
- alzheimers
- depression
- influenzal pneumonia
- scoliosis
- anemia
- diabetes (insulin dep)
- liver disease
- seizures
- arthritis
- diabetes (non insulin)
- lung disease
- shingles
- asthma
- eczema
- lupus erythema (discoid)
- past history of similar symptoms
- cancer
- emphysema
- lupus erythema (systemic)
- STD's (unspecified)
- cerebral palsy
- eye problems
- multiple sclerosis
- suicide attempt(s)
- chicken pox
- fibromyalgia
- parkinson's disease
- thyroid problems
- crohn's/colitis
- heart disease
- unspecified pleural effusion
- vertigo

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

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

- CRPS (RSD)     hepatitis     pneumonia     other:
- CVA (stroke)     HIV     psoriasis

**Surgery (ies): CHECK all that apply and WRITE the DATE of the Procedure immediately afterward.**

- angioplasty
- cosmetic
- hysterectomy
- pacemaker insertion
- appendectomy
- D & C
- joint reconstruction
- rotator cuff
- caesarian section
- dental surgery
- joint replacement
- spinal fusion
- cardiac catheterization
- gall bladder
- knee repair
- tonsilectomy
- carpal tunnel repair
- hemorrhoidectomy
- laminectomy
- other:
- coronary artery bypass
- hernia repair
- mastectomy

**Injury (ies): CHECK all that apply and WRITE the DATE of the Injury immediately afterward.**

- back injury
- head injury (loss of consciousness)
- motor vehicle accident
- broken bones
- head injury (no loss of consciousness)
- soft tissue injury (mild)
- disability (ies)
- industrial accident
- soft tissue injury (moderate)
- fall (severe)
- joint injury
- soft tissue injury (severe)
- fracture
- laceration (severe)
- other:

**Family History: CHECK all that apply. LIST any specific conditions past or present after has/had:**

- |             |                                |                                   |   |   |   |
|-------------|--------------------------------|-----------------------------------|---|---|---|
| father      | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| mother      | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| son (s)     | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| daughter(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s)  | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s)   | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |

**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: \_\_\_\_\_

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

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

**Chief Complaint – HPI (History of Present Illness)**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Dr: \_\_\_\_\_

Describe Chief Complaint: \_\_\_\_\_

**Body Area(s) Involved:**

- Neck       Upper Back       Mid Back       Low Back  
 Shoulder/Elbow/Wrist/Hand       Hip/Knee/Ankle/Foot

**Condition:**

- Acute ( less than 6 weeks old)     Chronic (older than 6 weeks)     Last Occurred: \_\_\_\_\_

**Mechanism of Onset:**

- Auto:      [ Driver/Passenger       On Foot Struck By Vehicle (refer to completed auto accident history form)]  
 Work Related:    [ Fall     Falling Object     Lifting     Repetitive Motion     Other: \_\_\_\_\_]  
 Other – Legal Action:    [ Slip and Fall     Other: \_\_\_\_\_]  
 Other – No Fault:    [ Cause Unknown     Overexertion     Repetitive Motion     Slept Wrong     Slip and Fall]

**Description of Onset of Complaint:** \_\_\_\_\_

**Current Symptoms:**

- Pain     Numbness     Stiffness     Weakness

**Location:**

Left / Right / Both Sides \_\_\_\_\_

**Quality:**

- Burning     Diffuse     Dull/Aching     Localized     Traveling to Another Area     Sharp  
 Shooting     Stabbing     Throbbing     Tightness     Tingling     Other \_\_\_\_\_

**Circle Level of Disability Due to Symptoms (Resting):**

0 None    1    2    3    4    5    6    7    8    9    10 Complete

**Circle Level of Disability Due to Symptoms (With Activity):**

0 None    1    2    3    4    5    6    7    8    9    10 Complete

**Duration:**

Started: \_\_\_\_\_  Hours Ago     Days Ago     Weeks Ago     Months Ago     Years Ago

Worsened: \_\_\_\_\_  Hours Ago     Days Ago     Weeks Ago     Months Ago     Years Ago

Injury/Accident Occurred: \_\_\_\_\_

**Timing:**

Worse:  Morning     Afternoon     Night     with Movement; Pain is:  Constant     Off and On

**Context:**

Better with:  Warm Temp     Cold Temp; Worse with:  Warm Temp     Cold Temp     Damp

**Assoc Signs and Symptoms:**  Blurred Vision  Depression  Dizziness  Irritability/Mood Swing

Tingling  Nausea  Ringing in Ears  Sleep Disturbance  Stiffness

**Headaches:** Location:  Back of Head  Front of Head  Top of Head  Left Temple  Right Temple  Face

Quality:  Dull  Sharp  Throbbing  Stabbing  Vision Changes  With Runny Nose

Time of Day: \_\_\_\_\_ Occurs: \_\_\_\_\_ Times Per: \_\_\_\_\_ Lasts: \_\_\_\_\_ Minutes/Hours

**Sensation Travels to Area:** Left / Right / Both Sides \_\_\_\_\_

**Weakness of Movement:** Left / Right / Both Sides \_\_\_\_\_

**Other Assoc Signs and Symptoms:**

- |                                       |  |   |  |  |
|---------------------------------------|--|---|--|--|
| <input type="checkbox"/> aches        | <input type="checkbox"/> burning         | <input type="checkbox"/> cold arms/legs | <input type="checkbox"/> difficulty walking  | <input type="checkbox"/> dizziness       |
| <input type="checkbox"/> bruising     | <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> fever          | <input type="checkbox"/> heartburn           | <input type="checkbox"/> joint stiffness |
| <input type="checkbox"/> muscle spasm | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> nausea         | <input type="checkbox"/> numbness            | <input type="checkbox"/> pale skin       |
| <input type="checkbox"/> panic        | <input type="checkbox"/> pins & needles  | <input type="checkbox"/> runny nose     | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> sweating        |
| <input type="checkbox"/> swelling     | <input type="checkbox"/> tingling        | <input type="checkbox"/> vomiting       |  |  |

**Modifying Factors:**

- Symptoms Better:  nothing helps  activity  bending  ice  heat  
 massage  movement  OTC meds  prescribed meds  rest  
 stretching  sitting  standing  twisting  walking

**Daily Activities: Effects of Current Condition on Performance**

<b>Bending:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Care of Sick Family:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Carrying Groceries:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Moving Sit to Stand:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Climb Stairs:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Driving:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Computer Use:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Eating:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Household Chores:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Kneeling:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Lifting Children:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Lifting Other:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Pet Care:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Reading/Concentration:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Self Care–Bathing:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Self Care–Dressing:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Self Care–Shaving:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Sexual Activities:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Sleep:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Sitting Still:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Standing Still:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Walking:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
<b>Yard Work:</b>	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform

**Employment:**

Occupation/Job Title: \_\_\_\_\_ Work: \_\_\_\_\_ hrs / day or week

Description of Work: \_\_\_\_\_

Job Classification:  Sedentary (lift<5lbs)  Light (lift 5-20lbs)  Mod (lift 20-50lbs)  Heavy (lift>50 lbs)

Lifting Frequency:  Constant (67-100%/day)  Frequent (33-66%/day)  Occasional (0-32%/day)

Lifting Postures:  With Arms  With Legs  When Bending  When Standing  Overhead

Work Activity Postures: (hrs/day)

bending: \_\_\_\_\_ h/d  climbing: \_\_\_\_\_ h/d  kneeling: \_\_\_\_\_ h/d  pulling: \_\_\_\_\_ h/d  pushing: \_\_\_\_\_ h/d

reaching: \_\_\_\_\_ h/d  sitting: \_\_\_\_\_ h/d  standing: \_\_\_\_\_ h/d  twisting: \_\_\_\_\_ h/d  walking: \_\_\_\_\_ h/d

Repetitive Activities: (hrs/day)

assembly/fine manipulation: \_\_\_\_\_ h/d  computer use/typing: \_\_\_\_\_ h/d  grasping: \_\_\_\_\_ h/d

hand tool use: \_\_\_\_\_ h/d  operation of machinery controls: \_\_\_\_\_ h/d  phone use: \_\_\_\_\_ h/d

**Condition's Effect On Job Performance:**

**Mild** Painful (Can do)      **Moderate** Painful (limited ability)      **Moderate/Severe** (Limited Duty)      **Severe** (Cannot perform duties)

**Recreational Activity: Effects of Current Condition on Performance**

\_\_\_\_\_ **No Effect**      **Mild** Painful (Can do)      **Mod** Painful (Limited)      **Sev** Unable to Perform

\_\_\_\_\_ **No Effect**      **Mild** Painful (Can do)      **Mod** Painful (Limited)      **Sev** Unable to Perform