

|             |           |
|-------------|-----------|
| Vital Signs |           |
| B/P: _____  | P: _____  |
| Temp: _____ |           |
| Ht: _____   | Wt: _____ |

*PLEASE PRINT*

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Appointment Date:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Who referred you?** \_\_\_\_\_

**Avocation/Hobbies:** \_\_\_\_\_ **With what diagnosis?** \_\_\_\_\_

**What is your chief complaint?** \_\_\_\_\_

**Describe its location.** \_\_\_\_\_

**When did this start?** \_\_\_\_\_

**Was it associated with an injury (explain)?** \_\_\_\_\_

**Characterize your symptom (numb, pressure, sharp, burning, cramping, throbbing, aching, locking, give-way):**

**Is it constant or intermittent (describe)?** \_\_\_\_\_

**What makes your symptom better?** \_\_\_\_\_

**What makes your symptom worse?** \_\_\_\_\_

**List any studies (x-rays, MRI, blood tests) performed to evaluate your condition:** \_\_\_\_\_

**Describe any treatments and their effects:** \_\_\_\_\_

**Does this affect your social and personal life?** \_\_\_\_\_

**Do you smoke?** \_\_\_\_\_ **How many packs per day?** \_\_\_\_\_ **For how many years?** \_\_\_\_\_

**Do you drink alcohol?** \_\_\_\_\_ **How much?** \_\_\_\_\_

**Circle symptoms you currently experience: FEVER, CHILLS, BLURRED VISION, DIZZINESS, RUNNY NOSE, SHORTNESS OF BREATH, COUGH, DIARRHEA, CONSTIPATION, URINARY INCONTINENCE/FREQUENCY, UNEXPLAINED WEIGHT LOSS, HEADACHE, RASH, EXCESSIVE BLEEDING, INSOMNIA, ANXIETY, INFECTION, NAUSEA/VOMITING, OTHER** \_\_\_\_\_

**List all previous surgeries:** \_\_\_\_\_

**Do you have a history of diabetes, high blood pressure, cancer, or heart, lung, liver, kidney or thyroid disease? If so, please explain:** \_\_\_\_\_

**Do you have a family history of the above mentioned diseases? If yes, please list:** \_\_\_\_\_

**List the medications that you are presently taking including any over-the-counter ones:** \_\_\_\_\_

**List any allergies to medications:** \_\_\_\_\_

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