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NAME:_____DOB_____

****Important: WHAT Part (s) of your body are hurting TODAY?- please indicate):**

neck ___ mid back___ lower back_____ Shoulder (both, right, left)_____ Wrist(both, right, left)_____ hand(both, right, left)___ hip (both, right, left)_____ knee(both, right, left)_____, foot (both, right, left)___ankle(both, right, left)_____. Other: _____

OCCUPATION:_____EDUCATION: ELEM HS COLLEGE POST GRAD

AGE:_____ HEIGHT:_____ WEIGHT:_____

Right or left handed?: _____

PRIMARY DR:_____ PHONE #:_____

ADDRESS:_____

PAST MEDICAL HISTORY AND REVIEW SYSTEMS

DO YOU HAVE A HISTORY OF PROBLEMS WITH YOUR (*CIRCLE APPLICABLE PROBLEM)?*

HEART: MURMUR, RHEUMATIC FEVER, HIGH BLOOD PRESSURE OR OTHER HEART PROBLEM?	Y / N
LUNGS: ASTHMA, EMPHYSEMA , BRONCHITIS OR OTHER LUNG PROBLEM?	Y / N
LIVER: YELLOW JAUNDICE OR LIVER DISEASE?	Y / N
URINARY TRACT: BLADDER OR KIDNEY PROBLEMS?	Y / N
GENITAL TRACT: PROSTATE OR REPRODUCTIVE ORGAN PROBLEMS?	Y / N
GASTROINTESTINAL TRACT: ESOPHAGUS, STOMACH, BOWEL, GALLBLADDER OR PANCREAS?	Y / N
ENDOCRINE SYSTEM: DIABETES, THYROID OR HYPOGLYCEMIA?	Y / N
BRAIN AND NERVOUS SYSTEM: SEIZURES, STROKE OR OTHER?	Y / N
BLOOD: BLEED EASILY, ANEMIA OR OTHER?	Y / N
EYES: GLAUCOMA OR OTHER?	Y / N
BONES AND JOINTS: GOUT, ARTHRITIS?	Y / N
SKIN:	Y / N
PSYCHOLOGICAL: DEPRESSION, ANXIETY OR OTHER?	Y / N
HAVE YOU HAD **T.B., AIDS / HIV, CANCER / TUMOR?**	Y / N

LIST YOUR PREVIOUS SURGICAL PROCEDURES AND DATES:_____

LIST YOUR ALLERGIES & DRUG ALLERGIES:_____

LIST YOUR CURRENT MEDICATIONS:_____

DO YOU HAVE A FAMILY HISTORY OF:

HEART DISEASE	Y / N	ALLERGIES	Y / N	STROKE	Y / N
HIGH CHOLESTROL	Y / N	ASTHMA	Y / N	CANCER	Y / N
HIGH BLOOD PRESSURE	Y / N	DIABETES	Y / N	OTHER_____	

SOCIAL HISTORY:

SMOKING / CHEW TOBACCO (PACKS/DAY)_____ALCOHOL (DRINKS/WEEK)_____
SUBSTANCE ABUSE_____CAFFEINE (CUPS/DAY)_____