Symptoms/Medical History

Name: _____ Date: _____

Diagnosis: _____ MD: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____lbs

Occupation: _____

What are you seeking treatment for? _____

When did the problem begin (give specific date if possible)? _____

Do you have: ___Pain ___Loss of motion ___Swelling ___Stiffness ___Loss of function

Rate your pain level: No pain Mild Moderate Severe Unbearable

Pain at the moment:	0	1	2	3	4	5	6	7	8	9	10
Most severe pain:	0	1	2	3	4	5	6	7	8	9	10
Least severe pain:	0	1	2	3	4	5	6	7	8	9	10

How did the problem begin? ___Unknown cause ___Illness ___Chronic condition ___Pregnancy/Birth

Injury (describe): _____

Surgery (describe): _____

Do you have: ___Numbness ___Tingling ___Throbbing ___Burning ___Shooting ___Twinges

What makes your symptoms worse? _____

What makes your symptoms better? _____

Are your symptoms worse in the: ___Morning ___Afternoon ___Evening ___Inconsistent ___Constant

Are your symptoms: ___Improving ___Staying the same ___Getting worse

How has this problem affected your daily life or exercise? _____
_____

Have you ever had similar symptoms before? Yes / No _____

Have you had any other treatment for this current problem? Did it help? Yes / No

___Medication	___Herbs	___Reiki/Energy
___Physical Therapy	___Craniosacral Therapy	___Nutrition
___Massage	___Chiropractic	___Exercise
___Acupuncture	___Homeopathy	___Other_____

Have you had any special tests (X-ray, MRI, CT Scan, Bone scan, Bone density, Ultrasound, Blood/Urine tests)?

Test_____ Date_____ Results_____
Test_____ Date_____ Results_____
Test_____ Date_____ Results_____
Test_____ Date_____ Results_____
Test_____ Date_____ Results_____

Describe your general health: Excellent____ Good____ Fair____ Poor____

Diet: _____

Exercise/Sports: _____

Medications/dosage:
_____
_____

Supplements: _____
_____

Do you drink alcohol? Yes / No If yes, how many drinks per day_____ per week_____ occasional_____

Caffeine: Yes / No If yes, how many cups per day____ Type: coffee____ tea____ soda____ diet soda____

Water/Non-caffeinated fluid intake: cups/day____

Have you experienced any of the following symptoms with your *current condition:*

___numbness (where?)
___tingling (where?)
___nausea/vomiting
___loss of appetite
___unexpected weight gain/loss
___chest pain/heart palpitations
___joint pain or swelling
___weakness in your arms/ legs
___intolerance to heat or cold
___constipation or diarrhea
___blood in stool or urine
___urinary urgency/frequency
___night sweats or pain
___fever or chills
___difficulty sleeping
___coordination problems
___shortness of breath
___skin changes (rash/color)
___vision changes
___fatigue/tiredness or malaise
___difficulty with walking
___headaches
___dizziness/fainting
___loss of balance
___difficulty swallowing
___hearing problems
___urinary incontinence

Are you seeing a doctor for the symptoms? Yes / No Name of doctor/s_____

Have you *ever* had any of any of the following:

___Cancer
___Diabetes
___Hypoglycemia
___High blood pressure
___Heart disease
___Vascular disease
___Blood disorders
___Head injury
___Urinary tract infection
___Allergies/Hay fever
___Asthma
___Liver Disease
___Chronic bronchitis
___Migraine headaches
___Stomach problems/Ulcers
___Rheumatoid arthritis/Gout
___Bladder problems
___Prostate problems
___Thyroid problems
___Digestive problems
___Fibromyalgia
___Lyme Disease
___Lymph node dissection
___Alcoholism/drug addiction
___Epilepsy/Seizures
___Osteoarthritis
___Osteoporosis/Osteopenia
___Fracture/broken bones
___Sprain/Muscle strain
___Chronic pain

Patient Signature_____ Date_____