Patient Information

Name:_____ **Date:**_____

Age:____ **Date of Birth:**_____ **Height:**_____ **Weight:**_____

Occupation, including activities that comprise your workday: _____

_____

Health Habits:

Smoking Currently: Yes No Alcohol: Current Past Never

Do you exercise beyond normal, daily activities and chores? Yes No Times/Week? ___

Hobbies/Leisure Activities:_____+_____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

Medical/Surgical Information:

Have you RECENTLY (past 3 months) had any of the following symptoms (check all that apply)?

☐ fatigue	☐ difficulty swallowing	☐ constipation/diarrhea
☐ fever/chills/sweats	☐ muscle weakness	☐ loss of appetite
☐ nausea/vomiting	☐ dizziness/lightheadedness	☐ shortness of breath
☐ weight loss/gain	☐ heartburn/indigestion	☐ fainting
☐ difficulty walking	☐ cough	☐ falls

☐ changes in bowel or bladder function (including but not limited to color, frequency)

☐ chest pain	☐ coordination problems	☐ headaches
☐ vision changes	☐ pain at night	☐ joint pain/swelling

Please check if you've EVER had any of the following conditions (check all that apply).

☐ cancer	☐ depression	☐ thyroid problems
☐ heart problems	☐ lung problems	☐ diabetes
☐ chest pain/angina	☐ tuberculosis	☐ osteoporosis
☐ high blood pressure	☐ asthma	☐ multiple sclerosis
☐ circulation problems	☐ rheumatoid arthritis	☐ epilepsy/seizure
☐ blood clots	☐ other arthritic condition	☐ eye problem/infection
☐ stroke	☐ bladder/urinary tract infect	☐ ulcers
☐ anemia	☐ kidney problem/infection	☐ liver problems
☐ bone or joint infection	☐ sexually transmitted diseas	☐ hepatitis
☐ chemical dependency	☐ pelvic inflammatory diseas	☐ pneumonia
☐ Fibromyalgia	☐ broken bones	☐ other

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

☐ cancer	☐ heart problems	☐ high blood pressure
☐ diabetes	☐ stroke	☐ depression
☐ tuberculosis	☐ thyroid problems	☐ blood clots

During the past month have you been feeling down, depressed or hopeless? Yes No

During the past month have you been bothered by having little interest or pleasure in doing things? Yes No

Is this something with which you would like help? Yes Yes, but not today No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? Yes No

Please list any medications/supplements you are currently taking (INCLUDING pills, injections, patches, and/ or over the counter medications/supplements/vitamins) (mark any that are new): _____

_____

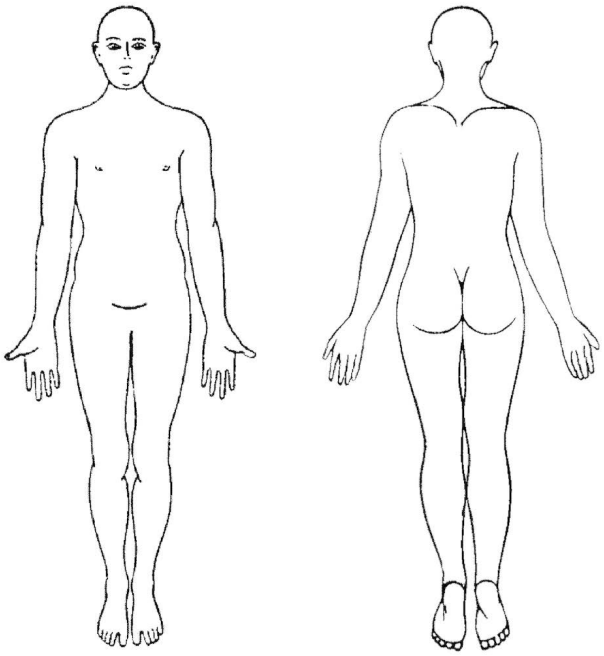
_____

Please list any surgeries/conditions/ trauma you have had: _____

_____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right:



My symptoms currently:

__ Come and go
__ Constant
__ Are constant, but change with activity
__ Stronger at night

Describe your sleeping habits:

__ No difficulty __ Difficulty falling asleep __ Awakened at night by pain, # of times/night ____

__ Sleep only with medication ____Average hours of sleep a night

Using the 0 to 10 scale, with 0 being "no pain" and 10 being the "uncontrollable pain", please describe:

Your current level of pain while completing this survey:
0 1 2 3 4 5 6 7 8 9 10
The best your pain has been over the past week:
0 1 2 3 4 5 6 7 8 9 10
The worst your pain has been over the past week:
0 1 2 3 4 5 6 7 8 9 10
Using the 0 to 10 scale, with 0 being "completely functional" and 10 being "unable to do anything", please describe:
0 1 2 3 4 5 6 7 8 9 10