Any past surgical History? For example: Carpal tunnel surgery 2008.

_____

_____

_____

Are you currently taking any medications?
If yes what?

_____ _____mg _____ _____mg

_____ _____mg _____ _____mg

_____ _____mg _____ _____mg

_____ _____mg _____ _____mg

Are you allergic to any medications? (circle one) YES or NO
If Yes, What? _____
What brings you to our office? (circle all that apply)
(Headaches) (Neck pain) (mid back pain) (lower back pain)
(Upper Extremity pain) (Lower Extremity Pain) (Other_____)

who referred you to this office? _____
Can we Send this person a thank you card? Yes No
Social History:
Marital Status: Married Single Divorced or Widowed

Do you have any children?_____ If yes how many_____
Are you Pregnant?_____ If yes how far along are you?_____

Smoking Status? (circle one) Never smoked**/** Current everyday smoker **/**Current some day smoker
Former smoker/ Unknown/ Heavy tobacco/ light tobacco
What date did you start smoking?_____ What date did you stop smoking?_____

Do you drink alcohol? Yes or No

Do you drink coffee? Yes or No

When did your symptoms begin?_____

What caused your symptoms?_____
_____

What size tshirt do you wear? **S M L XL 2XL 3XL** What shoe size do you wear? _____

_____Date_____ **_____Date_____**
Patient/ guardian Signature Douglas K. Reese, DC