Your Name: **DOB:**

Please complete the following as completely and truthfully as possible.
Please ask any of our staff for assistance if you have any questions or concerns.

Are you having any pain today? Y N

If so, how would you rate your pain?
(none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Where is your pain located? ______________________

How long have you had this pain?__________________

____

Do you use tobacco products? Y N

Do you drink alcoholic beverages? Y N

Do you have any allergies? Y N

If so, what are you allergic to? ___________________

How do you learn best? (circle any/all that apply)

Reading Listening Observing Doing

Your health care goals for your appointment:

____

____

Please tell us if you are having any of the following (circle any/all that apply): or None

Fever
Chills
Recent Weight Loss
Headache
Earache
Nasal Discharge
Nasal Blockage
Throat Pain
Chest Pain
Cough
Difficulty Breathing
Nausea
Vomiting
Abdominal Pain
Rectal Bleeding/Blood in Stool
Diarrhea
Constipation
Urinary Urgency
Urinary Frequency (times/night = _____)
Painful Urination
Back Pain
Lightheadedness

Eyesight Problems
Neck Pain or Stiffness
Swollen Glands
Wheezing
Chest Congestion
Fast or Irregular Heart Beat (palpitation)
Limb Swelling
Change in Appetite
Heartburn
Pain or Difficulty Swallowing
Cold/Heat Intolerance
Excessive Thirst
Excessive Bleeding (menstrual)
Easy Bruising
Urinary Loss of Control
Blood in the Urine
Muscle Aches
Limb Pain
Joint Pain
Joint Swelling
Fainting
Dizziness or Vertigo
Mood Problem (Anxiety or Depression)
Sleep Issues (Insomnia or Excessive)
Skin Rash