Patient Name: _____ *Medical History Intake Form*
Date of Birth: ____/____/____ **Age: ____** **Today's Date____/____/____**
MR#: **Referred By:**

Where do you have pain or a problem (which body part)?

Does the pain travel or radiate?	Yes	No	

How long have you had this problem? ____ weeks / months / years

Onset on pain?	gradual	sudden				
What makes it *worse*?	sitting	standing	walking	lying down	exercise	

Please describe what the pain feels like:
Achy, Sharp, Stabbing, Numbness, Tingling, Burning, Cramping, Stiff, Tight

Please make a *mark on the line* below to indicate the level of discomfort you have today.

No Pain ——————————————————— Worst Pain Ever
0 1 2 3 4 5 6 7 8 9 10

What diagnostic tests have you had done for this problem?			X-ray	MRI	CT scan	Ortho consult	EMG
What treatments have you had?	None	Meds	Injections	Physical Therapy		Psychotherapy	Chiropractic

Medications
(Current):

Medical/Surgical History:
ie Surgeries, Diabetes, Cancer,
High blood pressure, Heart attack,
Pacemaker, Arthritis, Fractures,
Accidents, Osteoporosis

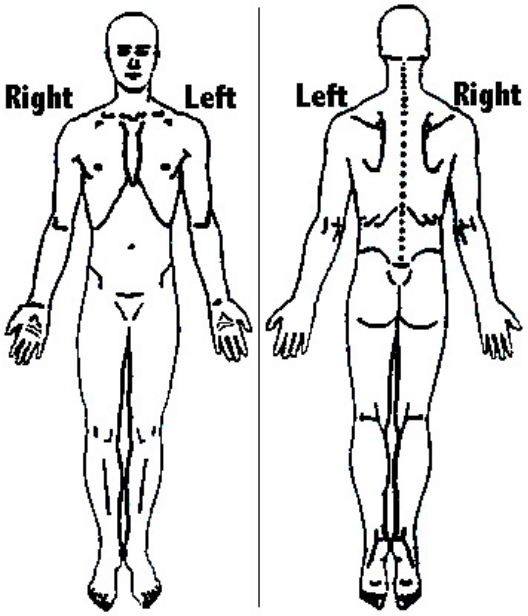
***Allergies* to medicines:**

Family History:
Cancer, Heart disease, Stroke,
Arthritis, Osteoporosis

***Social History:* Occupation:**

Tobacco use (cigarette, cigar, pipe, chew)**:**	Current	Quit	Never

Please draw where you have Pain



Review of Systems

Unexplained weight loss?	Yes	No
Vision change?	Yes	No
Headaches?	Yes	No
Chest pain?	Yes	No
Shortness of breath?	Yes	No
Loss of control of stools?	Yes	No
Loss of control of urine?	Yes	No
New rashes?	Yes	No
Weakness?	Yes	No
Depressed mood?	Yes	No
Sleep problems?	Yes	No
Anxiety?	Yes	No
Joint swelling?	Yes	No