



**Patient Intake**

**Date:** \_\_\_\_\_

Patient Name: \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ Age: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
 Phone (H): \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_  
 Marital Status: M S W D Spouses Name: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Who may we thank for referring you? \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Person Responsible For Account ME OTHER

Will you be using insurance? \_\_\_ Yes \_\_\_ No Insurance Company: \_\_\_\_\_  
 Was this due to an Auto Accident? \_\_\_ Yes \_\_\_ No If Yes, Auto Ins? \_\_\_\_\_ Is this a Work Related Injury? \_\_\_ Yes \_\_\_ No

Have you ever visited a Chiropractor? \_\_\_ No \_\_\_ Yes If Yes, whom? \_\_\_\_\_ Medical Dr's Name \_\_\_\_\_  
**WHEN DOCTORS WORK TOGETHER IT BENEFITS YOU. MAY WE HAVE YOUR PERMISSION TO UPDATE YOUR MEDICAL DOCTOR REGARDING YOUR CARE AT THIS OFFICE?** \_\_\_\_\_  
 Reason for today's visit 1) \_\_\_\_\_ 2) \_\_\_\_\_  
 3) \_\_\_\_\_ 4) \_\_\_\_\_  
 Please describe what happened: \_\_\_\_\_  
 When did this condition begin? \_\_\_\_\_ Is it? \_\_\_ Constant \_\_\_ Comes/Goes \_\_\_ Getting Worse  
 What makes it worse? \_\_\_\_\_ Does anything make it feel better? \_\_\_\_\_  
 Is it? \_\_\_ Burning \_\_\_ Aching \_\_\_ Stabbing \_\_\_ Dull \_\_\_ Radiating, Where? \_\_\_\_\_  
 Worse in: \_\_\_ Morning \_\_\_ During work \_\_\_ Evening after work \_\_\_ Middle of night \_\_\_ Other: \_\_\_\_\_  
 Have you ever had this before? \_\_\_ No \_\_\_ Yes If Yes, when? \_\_\_\_\_  
 Have you had recent x-rays? \_\_\_ Yes \_\_\_ No  
 Are you pregnant? \_\_\_ Yes \_\_\_ No \_\_\_ Not sure Date of Last Menstrual Period \_\_\_\_\_

Past Injuries (include auto, work, home, fractures, etc): \_\_\_\_\_

Medications/Supplements (include prescription/non-prescription): \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I authorize the release of my medical records and information to other healthcare providers, which this office may utilize or be in contact with such as my Primary Care Physician. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. The patient understand and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care.

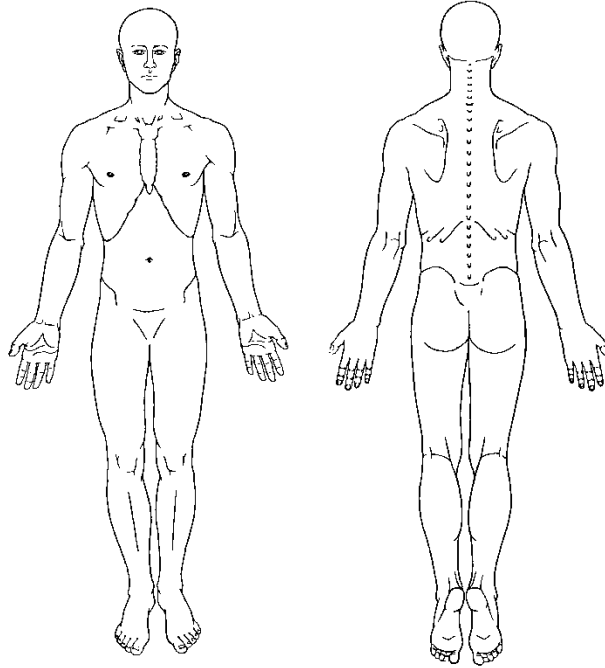
\_\_\_\_\_  
 Signature of Patient (or parent, if minor) Date

## TELL US WHERE YOU HURT

**Please read carefully:**

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>      Numbness =====      Pins & Needles o o o o  
Burning x x x x      Stabbing // //      Throbbing ~ ~ ~ ~



## GREAT PLAINS CHIROPRACTIC FINANCIAL POLICY

Dear Patient,

Thank you for choosing us as your health care provider. The following is our financial policy. The complexity of today's medical billing and insurance reimbursement can often make receiving health care very confusing. It is important to us that you understand the process from the beginning of care. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our office manager.

We do, in most instances, accept assignment of insurance benefits. However you must understand that.

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party of that contract.
2. All charges are your responsibility whether your insurance company pays or not. Some insurance companies select certain services they will not cover. Fee for these services are your responsibility, however we will attempt to make you aware of these situations as soon as possible.
3. Co-payments and co-insurance are due at the time of service.
4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact that carrier to help speed things up.
5. If the insurance company does not pay in full within 45 days. We may ask that you pay the balance due with cash or check.
6. A charge of 1.5% may be assessed on all balances over 30days old.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Thank you again for choosing us. We appreciate your trust, and the opportunity to serve you.

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

(Parents signature if a minor)

## QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name \_\_\_\_\_

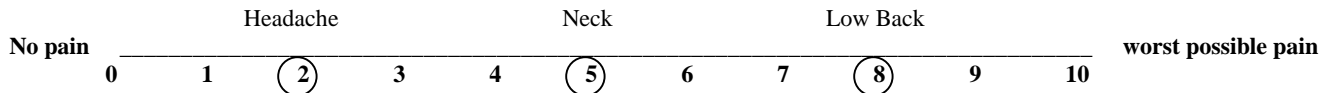
Date \_\_\_\_\_

**Please read carefully:**

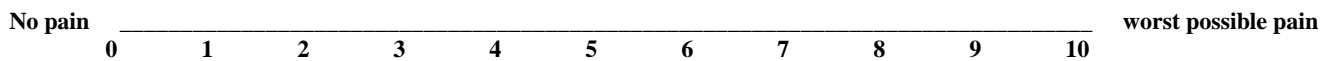
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

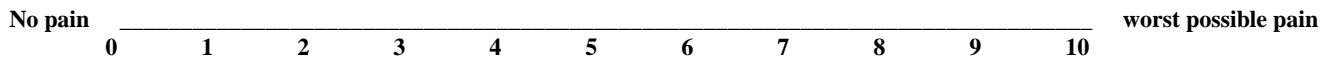
**Example:**



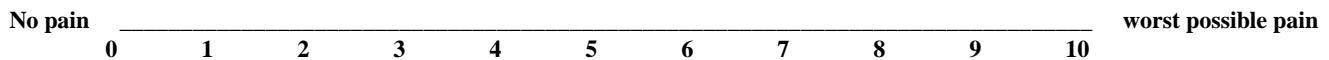
**1 – What is your pain RIGHT NOW?**



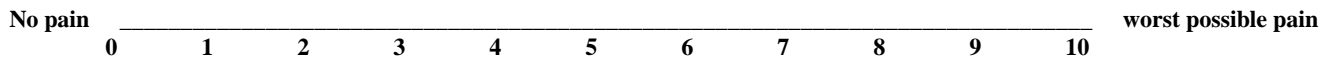
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**



**OTHER COMMENTS:**

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Examiner \_\_\_\_\_

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

**I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.**

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Name of Patient

Signature of Patient

Date

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

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**I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.**

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Name of Patient

Signature of Patient

Date

Please check any appropriate boxes if it applies to you to help us determine possible risk factors:

**GENERAL**

Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?

**BONE WEAKNESS**

Have you been diagnosed with osteoporosis?

Do you take corticosteroids (e.g. prednisone)?

Have you been diagnosed with a compression fracture(s) of the spine?

Have you ever been diagnosed with cancer?

Do you have any metal implants?

**VASCULAR WEAKNESS**

Do you take aspirin or other pain medication on a regular basis?

If yes, about how much do you take daily? \_\_\_\_\_

Do you take warfarin (Coumadin), heparin, or other similar “blood thinners”?

Have you ever been diagnosed with any of the following disorders/diseases?

- Rheumatoid arthritis
- Reiter’s syndrome, ankylosing spondylitis, or psoriatic arthritis
- Giant cell arteritis (temporal arteritis)
- Osteogenesis imperfect
- Ligamentous hypermobility such as with Marfan’s disease, Ehlers-Danlos syndrome
- Medial cystic necrosis (cystic mucoid degeneration)
- Bechet’s disease
- Fibromuscular dysplasia

Have you ever become dizzy or lost consciousness when turning your head?

**SPINAL COMPROMISE OR INSTABILITY**

Have you had spinal surgery?

If yes, when? \_\_\_\_\_

Have you been diagnosed with spinal stenosis?

Have you been diagnosed with spondylolithesis?

Have you had any of the following problems?

- Sudden weakness in the arms or legs?
- Numbness in the genital area?
- Recent inability to urinate or lack of control when urinating?

**I also understand that my condition may worsen and referral may be necessary if a course of chiropractic care does not help or improve my condition. I have read the previous information regarding risks of chiropractic care and my doctor has explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my question have been answered to my satisfaction. I agree to this plan of care.**

**PATIENT’S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

(Parent/Guardian’s signature if minor)

# Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## **Pain Intensity**

- ① The pain comes and goes and is very mild.
- ② The pain is mild and does not vary much.
- ③ The pain comes and goes and is moderate.
- ④ The pain is moderate and does not vary much.
- ⑤ The pain comes and goes and is very severe.
- ⑥ The pain is very severe and does not vary much.

## **Sleeping**

- ① I get no pain in bed.
- ② I get pain in bed but it does not prevent me from sleeping well.
- ③ Because of pain my normal sleep is reduced by less than 25%.
- ④ Because of pain my normal sleep is reduced by less than 50%.
- ⑤ Because of pain my normal sleep is reduced by less than 75%.
- ⑥ Pain prevents me from sleeping at all.

## **Sitting**

- ① I can sit in any chair as long as I like.
- ② I can only sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting more than 1 hour.
- ④ Pain prevents me from sitting more than 1/2 hour.
- ⑤ Pain prevents me from sitting more than 10 minutes.
- ⑥ I avoid sitting because it increases pain immediately.

## **Standing**

- ① I can stand as long as I want without pain.
- ② I have some pain while standing but it does not increase with time.
- ③ I cannot stand for longer than 1 hour without increasing pain.
- ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ⑥ I avoid standing because it increases pain immediately.

## **Walking**

- ① I have no pain while walking.
- ② I have some pain while walking but it doesn't increase with distance.
- ③ I cannot walk more than 1 mile without increasing pain.
- ④ I cannot walk more than 1/2 mile without increasing pain.
- ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ⑥ I cannot walk at all without increasing pain.

## **Personal Care**

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ② I do not normally change my way of washing or dressing even though it causes some pain.
- ③ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ④ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ⑤ Because of the pain I am unable to do some washing and dressing without help.
- ⑥ Because of the pain I am unable to do any washing and dressing without help.

## **Lifting**

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor.
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⑤ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑥ I can only lift very light weights.

## **Traveling**

- ① I get no pain while traveling.
- ② I get some pain while traveling but none of my usual forms of travel make it worse.
- ③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ④ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⑤ Pain restricts all forms of travel except that done while lying down.
- ⑥ Pain restricts all forms of travel.

## **Social Life**

- ① My social life is normal and gives me no extra pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ④ Pain has restricted my social life and I do not go out very often.
- ⑤ Pain has restricted my social life to my home.
- ⑥ I have hardly any social life because of the pain.

## **Changing degree of pain**

- ① My pain is rapidly getting better.
- ② My pain fluctuates but overall is definitely getting better.
- ③ My pain seems to be getting better but improvement is slow.
- ④ My pain is neither getting better or worse.
- ⑤ My pain is gradually worsening.
- ⑥ My pain is rapidly worsening.

Back  
Index  
Score

# Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## **Pain Intensity**

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

## **Sleeping**

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

## **Reading**

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

## **Concentration**

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

## **Work**

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

## **Personal Care**

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

## **Lifting**

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

## **Driving**

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

## **Recreation**

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

## **Headaches**

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Neck  
Index  
Score

**PATIENT REVIEW OF SYSTEMS**

Please check the “**current**” box for all conditions that you are now experiencing and mark the “**recent**” box for any condition or symptom(s) experienced at any time in your life. Please do not write in the spaces marked “**Doctor’s Notes Only**”.

	<b>Current</b>	<b>Recent</b>
<b>GENERAL</b>		
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>
Change in routine	<input type="checkbox"/>	<input type="checkbox"/>
<b>HEAD</b>		
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Head trauma	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Blacking out	<input type="checkbox"/>	<input type="checkbox"/>
<b>EYES</b>		
Change in vision	<input type="checkbox"/>	<input type="checkbox"/>
Glasses/Contacts	<input type="checkbox"/>	<input type="checkbox"/>
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to light	<input type="checkbox"/>	<input type="checkbox"/>
Flashes in vision	<input type="checkbox"/>	<input type="checkbox"/>
Spots in vision	<input type="checkbox"/>	<input type="checkbox"/>
<b>EARS</b>		
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Frequent infection	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Drainage	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>
<b>NOSE</b>		
Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
<b>MOUTH</b>		
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>
Changes in taste	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
<b>NECK</b>		
Masses	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>

	<b>Current</b>	<b>Recent</b>
<b>LUNGS</b>		
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up phlegm	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
<b>VASCULAR</b>		
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>
Cold feet or hands	<input type="checkbox"/>	<input type="checkbox"/>
Discolored foot/hand	<input type="checkbox"/>	<input type="checkbox"/>
Hot feet or hands	<input type="checkbox"/>	<input type="checkbox"/>
Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>
Calf pain	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
<b>G-I SYSTEM</b>		
Gas	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting/Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
<b>G-U SYSTEM</b>		
Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>
Pain urinating	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Foul odor of urine	<input type="checkbox"/>	<input type="checkbox"/>
Increased urination	<input type="checkbox"/>	<input type="checkbox"/>
Decreased urination	<input type="checkbox"/>	<input type="checkbox"/>
Urinary infection	<input type="checkbox"/>	<input type="checkbox"/>
Genital infection	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>

**Patient Name** \_\_\_\_\_

**Date** \_\_\_\_\_

	<b>Current</b>	<b>Recent</b>
<b>PSYCHOLOGIC</b>		
Excessive Stress	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>
<b>SKIN</b>		
Rash	<input type="checkbox"/>	<input type="checkbox"/>
Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>
Warts	<input type="checkbox"/>	<input type="checkbox"/>
Brittle nails	<input type="checkbox"/>	<input type="checkbox"/>
Changes in moles	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Peeling	<input type="checkbox"/>	<input type="checkbox"/>
<b>NEUROLOGIC</b>		
Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Strokes	<input type="checkbox"/>	<input type="checkbox"/>
Tingling sensation	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>
Poor coordination	<input type="checkbox"/>	<input type="checkbox"/>
<b>MUSCLE/BONE</b>		
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle ache	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Bone pain	<input type="checkbox"/>	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Dislocations	<input type="checkbox"/>	<input type="checkbox"/>
<b>CONDITIONS</b>		
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Cancer / Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
<b>VACCINATIONS</b> IF AGE > 60 y/o		
Flu	<input type="checkbox"/>	<input type="checkbox"/>
Varicella	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>

	<b>Current</b>	<b>Recent</b>
<b>MEDICATION</b>		
Prescription medications	<input type="checkbox"/>	<input type="checkbox"/> (please bring a list).
Non-prescribed medication.	<input type="checkbox"/>	<input type="checkbox"/> (please bring a list)
Drug allergies	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>
<b>MEDICAL</b>		
Surgery-any area	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>
Prior prescriptions	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>
Last laboratory test	<input type="checkbox"/>	<input type="checkbox"/>
Last chest x-ray		
(for those over age 55)		
<b>SOCIAL</b>		
Consume alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Consume coffee	<input type="checkbox"/>	<input type="checkbox"/>
Consume tea	<input type="checkbox"/>	<input type="checkbox"/>
Consume sodas	<input type="checkbox"/>	<input type="checkbox"/>
Smoker	<input type="checkbox"/>	<input type="checkbox"/>
Aerobic exercise	<input type="checkbox"/>	<input type="checkbox"/>
Water intake/day	<input type="checkbox"/>	<input type="checkbox"/>
Herbs	<input type="checkbox"/>	<input type="checkbox"/>
Hobbies	<input type="checkbox"/>	<input type="checkbox"/>
Vitamins (bring a list)	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Drink ___ glasses water/day		
Sleep _____ hours/night		
<b>OB GYN – For Females</b> List Dates as Indicated		
Age period began		_____
Last breast exam		_____
Last PAP date		_____
Pregnancy(s)- past		_____
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>
Lumps in breast	<input type="checkbox"/>	<input type="checkbox"/>
Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
PMS	<input type="checkbox"/>	<input type="checkbox"/>
Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>
<b>FAMILY HISTORY</b>		
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Colorectal Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>