INITIAL HEALTH STATUS

Patient Name:______________________________ Birthdate____________ Ht.______ Wt.______

Describe Your Current Problem and how it began: Date it began______________

____

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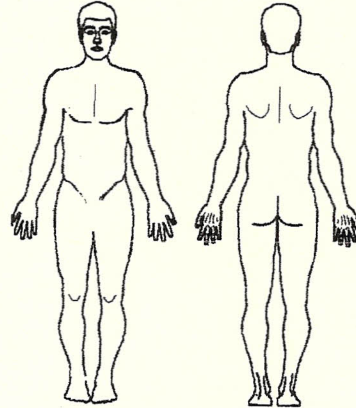
Mark an X on the Picture where you have pain



How you feel today:

____

0 1 2 3 4 5 6 7 8 9 10
No pain Moderate Unbearable pain

How Often are your symptoms present?
__0-25% __26-50% __51-75% __76-100%

Can you perform your daily activities? __Yes__No
If no, please explain__________________________

____

Have you had spinal X-rays?__Yes__No
MRI or CT Scan? ____Yes____No

PRESENT COMPLAINTS

- ☐ HEADACHE
- ☐ HEAD FEELS HEAVY
- ☐ HEAD/SHOULDERS TIRED
- ☐ MENTAL DULLNESS
- ☐ LOSS OF MEMORY
- ☐ EQUILIBRIUM PROBLEMS
- ☐ DIZZINESS
- ☐ FAINTING
- ☐ TREMORS
- ☐ PALPITATIONS
- ☐ NECK PAIN/STIFFNESS
- ☐ NECK MOTION RESTRICTED
- ☐ UPPER BACK PAIN/STIFFNESS
- ☐ MID BACK PAIN/STIFFNESS
- ☐ LOW BACK PAIN/STIFFNESS
- ☐ NUMBNESS/TINGLING (CIRCLE) ARM L/R, LEG L/R, FINGERS L/R

HAVE YOU SEEN ANOTHER DOCTOR?
YES/NO
LIST____________________________

____

____

PRIOR ACCIDENTS? YES/NO
DATE(s)_________________________

____

PRIOR INJURIES?_________________

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- ☐ CHEST PAIN
- ☐ STROKE
- ☐ HIGH BLOOD PRESSURE
- ☐ SHORTNESS OF BREATH
- ☐ EYE STRAIN
- ☐ PAIN BEHIND EYES
- ☐ EYES SENSITIVE TO LIGHT
- ☐ EYES LOSS OF FOCUS
- ☐ DOUBLE VISION
- ☐ EARS BUZZING/RINGING
- ☐ LOSS OF TASTE
- ☐ LOSS OF SMELL
- ☐ SINUS TROUBLE
- ☐ EXTREME NERVOUSNESS
- ☐ TENSION
- ☐ IRRITABILITY
- ☐ ANXIETY
- ☐ EXTREME FATIGUE
- ☐ DEPRESSION
- ☐ INSOMNIA

- ☐ DIGESTIVE DISORDERS
- ☐ NAUSEA
- ☐ VOMITING
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ FREQUENT URINATION
- ☐ SWELLING__________
- ☐ FEET/HANDS COLD

☐ OTHER SYMPTOMS:

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MEDICATIONS____________

____

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VITAMINS/SUPPLEMENTS___

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PAST MEDICAL HISTORY:

____

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____

SOCIAL
- ☐ ALCOHOL USE____OZ/WK
- ☐ TOBACCO USE___PK/DAY

FAMILY HISTORY:
- ☐ CANCER
- ☐ DIABETES
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART PROBLEMS
- ☐ STROKE

SIGNATURE______________________________	DATE______________