Name: _____ DOB _____ _____Date: _____

What is the reason for coming in? What hurts? _____

_____

Is it a chronic condition that has become worse? _____(Y/N) Are you coming in for maintenance? _____(Y/N)

How did it happen? _____

Is it a result of an accident, or injury? _____(Y/N) If so, please describe: _____

_____

Approximate or known date: _____

How would you rank the pain on a scale of 0 to 10, 0 being no pain, 10 being excruciating pain that you would be in the emergency room with:

Now: _____/10 When the pain is at its least: _____/10 When the pain is at its most: _____/10

How often are you experiencing the pain? (Check your answer)

_____Comes and goes (intermittent) _____ Up to 30% of the day (occasionally)

_____50-75% of the time (frequently) _____75-100% of the day (constantly)

Is your sleep affected? _____ (Y/N), if so, please describe: _____

What does the sensation feel like? Please circle the following that apply to you.

Sharp Dull Achy Burning Numbness Tingling Throbbing Stabbing
Shooting Stiff Numbness Crawling Cramping Other: _____

Do any of the following treatments make the problem better? Please circle all that apply to you.

Ice Heat Exercise Rest Massage Prescription medications Sitting
Standing Bending Lifting Twisting Lying down Over-the-counter pain medication
Adjustments Sitting

Do any of the following make the problem worse? Please circle all that apply to you.

Bending Lifting Twisting Sitting Standing Lying down Kneeling
Pushing Pulling Driving Reaching Exercise Dressing Bathing
Gripping Reaching Throwing Sleeping Climbing Turning over Standing
Sexual Activity
Bowel Movements Getting up from sitting Getting into/out of a car Climbing/Descending stairs

Does the pain travel anywhere? Yes/No (circle) **If so, where?** _____

What are you unable to do because of this condition that you wish you could do?

_____

Please circle all of the body areas that you ARE EXPERIENCING stiffness, soreness, pain, discomfort etc. Circle left or right.

L or R Head L or R Neck L or R Mid back L or R Low back L or R Pelvis
L or R Hips L or R Knee L or R Ankle L or R Foot L or R Toe
L or R Shoulder L or R Elbow L or R Wrist L or R Hand L or R Finger

Please circle all of the body areas that HAVE EXPERIENCED stiffness, soreness, pain, discomfort etc.. Circle left or right.

L or R Head L or R Neck L or R Mid back L or R Low back L or R Pelvis
L or R Hips L or R Knee L or R Ankle L or R Foot L or R Toe
L or R Shoulder L or R Elbow L or R Wrist L or R Hand L or R Finger

Occupation: _____

Please Initial: _____

Name: _____ DOB _____ Date: _____

Review of Systems/ Health History

Please check √ any of the following symptoms that you have experienced now or in the past:

Now	Past	**Musculoskeletal**	Now	Past	**Nose/Mouth/Throat**	Now	Past	**Lungs**	Now	Past	**Autoimmune**
		Neck Pain			Sinus infection			Asthma			ALS
		Neck Stiffness			Chronic sinusitis			Shortness of breath			Lupus
		Jaw pain			Frequent nose bleeds			Wheezing			Rheumatoid Arthritis
		Midback pain			Broken nose			Allergies			Ankylosing Spondylitis
		Low Back Pain			Bleeding gums			COPD			Fibromyalgia
		Leg Pain			Canker sores			Snoring			Parkinson's
		Knee Pain			Strep throat			Cough			MS
		Ankle Pain			Tonsilitis			Sleep Apnea	Now	Past	**Kidney**
		Foot Pain			Tonsils/ Adenoids removed (circle)			Chronic bronchitis			Incontinence
		Shoulder pain			Difficulty swallowing	Now	Past	**Cardiovascular System**			Frequent urination
		Elbow pain			Polyps			Cold hands/feet (circle)			Painful urination
		Wrist Pain	Now	Past	**Gastrointestinal**			Circulation problems			Kidney stones
		Hand Pain			Ulcers			Chest pain			UTI
		Migraine			Vomiting			High Blood Pressure			Kidney failure
		Headache			Diarrhea			High cholesterol			Pitting edema
Now	Past	**Eyes**			Constipation			Reynauds			Decreased urination
		Double vision			IBS			Heart attack	Now	Past	**Hernia**
		Lazy eye			Colitis			Ankle swelling			Hiatal
		Blurred vision			Chrons			Varicose veins			Inguinal
		Macular degen.			Diverticulosis	Now	Past	**Nervous System**	Now	Past	**Psychological**
		Nearsighted			Nausea			Restless leg syndrome			Depression
		Farsighted			Bloody stools			Numbness			Bipolar
		Contacts			Parasites			Burning			Personality Disorder
		Glasses			Gastric Reflux			Tingling			Scizophrenia
		Catatracts	Now	Past	**Skin**			Drop foot			Anxiety
		Glaucoma			Eczema			Seizures			
		Pink eye			Psoriasis	Now	Past	**Endocrine (hormone)**			
Now	Past	**Ears**			dry/oils skin (circle)			Thyroid problems			
		Ringing			dry/oily hair (circle)			Adrenal fatigue			
		Deafness			Rash			Diabetes Type I			
		Cochlear implants			Hives			Diabetes Type II			**Men Only**
		Ruptured eardrum			Acne			Dizziness			Prostate
		Ear infections			Ingrown hair			Paralysis			Erectile Dysfunction
		Swimmers ear			Brittle nails			Confusion			Infertility
		Dizziness						Convulstions			STD

Name: _____ DOB _____ Date: _____

For Females ONLY:

Please circle if you have had any of the following:

Painful intercourse	PMS	Complete Hysterectomy	Partial Hysterectomy	Tubal Ligation
Vaginal Ablation	PCOS	Fibrotic breasts	Vaginal Discharge	Endometriosis
Yeast Infections	STD	Menstrual Cramps	Irregular Menses	Menopause

_____ # of pregnancies _____# of live births _____ # of miscarriages _____# of abortions

Current Health Habits:

What is your diet like? What kinds of foods do you consume?

_____

How much water do you consume per day? _____ How many caffeinated beverages? _____
How many soft drinks? _____Alcoholic beverages per day? _____
Alcoholic beverages per weekend? _____ How much exercise and what kind of exercise do you do?

_____

Do you exercise? If so, please describe type of exercise, days per week and what duration you exercise for. _____

_____

Past Accidents and Surgeries, please list approximate dates: _____

_____

_____

_____

_____

_____

Please list all significant family history of genetic family members including parents, grandparents, siblings and children. _____

_____

_____

_____

_____

_____

Please list any medications that you are currently taking and what they are used for: _____

_____

_____

_____

_____

_____

Anything else important that you want Dr. Erin Denil to know? _____

_____

_____

The information on pages 1-3 are accurate and complete to the best of my knowledge at this time.

Please sign: _____ **Date:** _____

Please Initial: _____