Name: _____ **Date:** _____

Is today's visit due to: Illness Accident Injury Other _____
Job related ☐ Yes ☐ No Automobile related? ☐ Yes ☐ No

How did your symptoms begin? _____

What activities *improve or relieve* your symptoms? _____

Medicine/supplements currently taking? _____

List past Surgeries/Injections: _____
Have you been treated for this condition before? ☐ Yes ☐ No If yes, by whom? _____
Are you *currently* under a healthcare provider's care for any other problems? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No ☐ Never Packs per day? _____ How many years? _____
Do you use alcohol? ☐ Yes ☐ No ☐ Never Drinks per day? _____ per week? _____
Do you use recreational drugs? ☐ Yes ☐ No ☐ Never How often? _____

CHRONIC ILLNESSES *(Check the disorders that you currently have) fill in type of condition on line next to illness*

☐ Alcoholism/Substance Abuse
☐ AIDS/HIV/ARC
☐ Anemia
☐ Asthma
☐ Cancer _____
☐ Diabetes
☐ Emphysema
☐ Epilepsy or Seizures
☐ Fibromyalgia
☐ Gout
☐ Hayfever
☐ Heart Disease
☐ Heart Failure
☐ Hepatitis_____ ____
☐ Herpes _____
☐ Hypertension
☐ Kidney Disease
☐ Mental Illness _____
☐ Migraine Headaches
☐ Miscarriages/Abortions
☐ Mitral Valve Prolapse
☐MultipleSclerosis
☐ Polio
☐Rheumatic Fever
☐ Stroke or TIA
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers

PLEASE *CIRCLE* THE FOLLOWING SYMPTOMS WHICH YOU HAVE NOW OR *CHECK* NEXT TO CONDITIONS YOU PREVIOUSLY HAD.

General
Convulsions
Dizziness or fainting
Environmental allergies
Fatigue easily
Headaches
Loss of balance
Nerve pain
Nervousness or anxiety
Night sweats

Muscle/Joint
Arthritis/rheumatism
Bursitis
Foot trouble
Low back pain
Neck pain/stiffness
Pain between shoulders
Pain / numb / tingle in:
☐ elbows ☐ hands
☐ shoulders ☐ arms
☐ hip ☐ legs
☐ knees ☐ feet
Sciatica
Scoliosis
Swollen joints _____
Tremors
Weakness

Eyes-Ears-Nose-Throat
Deafness or hearing loss
Ear Discharge
Ear noises
Earache or ear pain
Eye infections
Eye pain
Frequent colds
Frequent sore throats
Nasal discharge
Nosebleeds
Sinus infections

Heart
Chest pain/angina
Hardening of the arteries
Heart attack
High blood pressure Low blood pressure
Palpitations
Phlebitis
Poor circulation
Rapid heart beat
Rheumatic heart disease
Skipped heart beats
Slow heart beats
Swelling of ankles/legs

Gastrointestinal
Abdominal distention
Constipation
Diarrhea
Food eruptions/reflux
Gallbladder trouble
Hemorrhoids
Irritable bowel syndrome
Liver problems
Spastic colons
Stomach pain
Ulcer disease

Respiratory
Asthma
Chronic cough
Difficulty breathing
Pain when breathing
Shortness of breath
Spitting up blood
Spitting up phlegm
Wheezing

***Women* only**
Breast lumps or pain
Excessive menstrual flow
Menopausal symptoms
Hot flashes
Irregular menstrual cycle
Menstrual cramps
Vaginal discharge

Genitourinary
Bedwetting
Blood in urine
Difficulty urinating
Frequent urination
Incontinence
Kidney infection/stones
Painful urination
Pus in urine
Sexual transmitted disease
_____
_____

Skin
Acne
Easy bruising
Eczema
Hives
Rashes
Skin dryness
Skin oiliness
Varicose veins

***Men* only**
Impotence
Prostate