PATIENT SELF ASSESSMENT

Patient's Full Name:______	Today's Date:______
Please Put Your Email If You Would Like To Receive Our Monthly Newsletter______	Age:_____ Height:______Weight:____
	Dominant Hand: L R
Primary Care Physician:______	Occupation:______
Their Address/Phone:______	Do You Smoke?______
I Was Referred By:______	If So, How Much______
Reason For Today's Visit:______	Do You Drink?______
Is This Related To: (Please Put The Date It Started)	If So, How Much?______
Φ Work Injury______	Do You Exercise?______
Φ Motor Vehicle Accident______	If So, How Much?______
ν Other______	

HEAD, NECK, BACK, EXTREMITIES Check symptoms you currently have or have had in the past year.

HEAD	Left	Right
☐ Headaches	☐ L	☐ R
☐ Migraines	☐ L	☐ R
☐ Face pain	☐ L	☐ R
☐ Jaw pain	☐ L	☐ R
NECK		
☐ Pain in neck	☐ L	☐ R
☐ Neck stiffness	☐ L	☐ R
☐ Neck weakness	☐ L	☐ R
☐ Grinding sounds in neck	☐ L	☐ R
☐ Tingling in the neck	☐ L	☐ R
☐ Neck feels out of place	☐ L	☐ R
MIDBACK		
☐ Midback pain	☐ L	☐ R
☐ Midback stiffness	☐ L	☐ R
☐ Pain between shoulder blades	☐ L	☐ R
☐ Muscle spasms in midback	☐ L	☐ R
☐ Midback feels out of place	☐ L	☐ R
LOWER BACK		
☐ Pain in lower back	☐ L	☐ R
☐ Lower back stiffness	☐ L	☐ R
☐ Muscle spasms in lower back	☐ L	☐ R
☐ Lower back feels out of place	☐ L	☐ R
SHOULDERS		
☐ Pain in shoulder	☐ L	☐ R
☐ Pain across tops of shoulders	☐ L	☐ R
☐ Can't raise arm	☐ L	☐ R
☐ Above shoulder level	☐ L	☐ R
☐ Overhead	☐ L	☐ R
☐ Tingling in shoulder	☐ L	☐ R
☐ Tension in shoulder	☐ L	☐ R
☐ Numbness in shoulder	☐ L	☐ R

ARMS & HANDS	Left	Right
☐ Pain in upper arm	☐ L	☐ R
☐ Pain in elbow	☐ L	☐ R
☐ Pain in forearm	☐ L	☐ R
☐ Pain in hand/fingers	☐ L	☐ R
☐ Pins/needles feeling in arm	☐ L	☐ R
☐ Pins/needles feeling in finger	☐ L	☐ R
☐ Numbness in arm	☐ L	☐ R
☐ Numbness in hand/fingers	☐ L	☐ R
☐ Weak arm/hand	☐ L	☐ R
HIPS, LEGS & FEET		
☐ Pain in buttocks	☐ L	☐ R
☐ Pain in hip joint	☐ L	☐ R
☐ Pain down leg	☐ L	☐ R
☐ Pain in knee	☐ L	☐ R
☐ Pain in ankle	☐ L	☐ R
☐ Pain in foot	☐ L	☐ R
☐ Pain in toes	☐ L	☐ R
☐ Pins/needles in leg	☐ L	☐ R
☐ Pins/needles in toes	☐ L	☐ R
☐ Numbness in leg	☐ L	☐ R
☐ Numbness in foot/toes	☐ L	☐ R
☐ Weakness of leg	☐ L	☐ R
☐ Weakness of knee	☐ L	☐ R
☐ Leg cramps	☐ L	☐ R
☐ Cold feet	☐ L	☐ R

OTHER SYMPTOMS:

______
______
______
______
______

If you have a family history of any medical problems, please list them:______

______
______

GENERAL SYMPTOMS Check symptoms you currently have or have had in the past year.

GENERAL

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Bleeding Disorders
- ☐ Cancer/Tumors
- ☐ Chemical Dependency
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting or Seizures
- ☐ Fibromyalgia
- ☐ Forgetfulness
- ☐ Gout
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Multiple Sclerosis
- ☐ Nervousness
- ☐ Night Sweats
- ☐ Osteoporosis
- ☐ Paralysis
- ☐ Psychiatric Care
- ☐ Stroke
- ☐ Tiredness
- ☐ Thyroid Problems
- ☐ Weight Change (dramatic)

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Poor Circulation
- ☐ Swelling of Ankles
- ☐ Varicose Veins

EYE, EAR, NOSE, THROAT

- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Double Vision
- ☐ Floaters/Haloes
- ☐ Glaucoma
- ☐ Earache
- ☐ Hearing Loss
- ☐ Ringing in ears
- ☐ Vertigo (dizziness)
- ☐ Allergies/Hayfever
- ☐ Nasal Drip
- ☐ Nosebleeds
- ☐ Sinus Problems
- ☐ Bleeding Gums
- ☐ Chronic Cough
- ☐ Difficulty Swallowing
- ☐ Slurred Speech
- ☐ Throat Hoarseness

RESPIRATORY

- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Mono
- ☐ Emphysema
- ☐ COPD
- ☐ Shortness of Breath

SKIN

- ☐ Bruises Easily
- ☐ Changes in Moles
- ☐ Eczema/Psoriasis
- ☐ Hives/Rash
- ☐ Itching
- ☐ Skin Cancer
- ☐ Sores not healing

GASTRO-INTESTIONAL

- ☐ Poor Appetite
- ☐ Black/Bloody Stool
- ☐ Bloating/Gas
- ☐ Bowel Changes
- ☐ Colitis/IBS
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Indigestion
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Loss of bowel control
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Reflux
- ☐ Stomach Pain
- ☐ Ulcers
- ☐ Vomiting
- ☐ Weight Trouble

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Difficulty starting flow
- ☐ Difficulty stopping flow
- ☐ Frequent Urination
- ☐ Incontinence
- ☐ Milky/Bloody Urine
- ☐ Painful Urination

PLEASE LIST ALLERGIES OR REACTIONS:

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____
____
____

MEN ONLY

- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Prostate Problems

WOMEN ONLY

- ☐ Abnormal Pap Smear
- ☐ Abnormal Periods
- ☐ Breast Lumps/Pain
- ☐ Cysts/Tumors
- ☐ Discharge
- ☐ Dysmenorrhea
- ☐ Endometriosis
- ☐ Extreme Cramps
- ☐ Hot Flashes
- ☐ Miscarriage
- ☐ Spotting

Date of last menstrual period__________________

Are you pregnant?________

If so, how far along are you?________________

Number of Children______

Have you had a Mammogram?___________

OTHER:

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Please list medications you currently are taking:

Please assist us by filling out your surgical history including dates:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature____ **Date**____________________