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Patient Name: _____ Date: _____

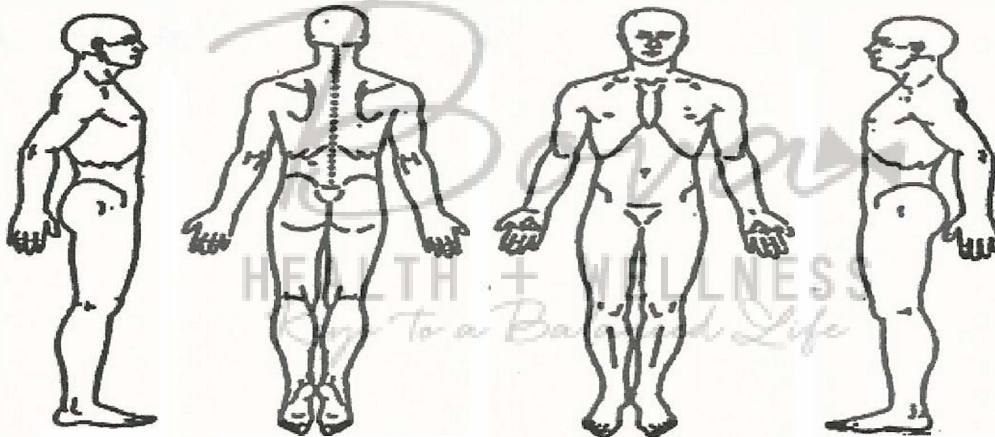
Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

Date of Birth: _____ Referred By: _____

1. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- | | |
|-----------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Constantly (76-100% of the time) | <input type="checkbox"/> Occasionally (26-50% of the time) |
| <input type="checkbox"/> Frequently (51-75% of the time) | <input type="checkbox"/> Intermittently (1-25% of the time) |

4. How would you describe the type of pain? Not Applicable

- | | |
|-----------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Numb |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Tingly |
| <input type="checkbox"/> Diffuse | <input type="checkbox"/> Sharp with motion |
| <input type="checkbox"/> Achy | <input type="checkbox"/> Shooting with motion |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing with motion |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff | <input type="checkbox"/> Other: _____ |

5. How are your symptoms changing with time?

- | | | |
|----------------------------------------|-------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Getting Worse | <input type="checkbox"/> Staying the Same | <input type="checkbox"/> Getting Better |
|----------------------------------------|-------------------------------------------|-----------------------------------------|

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

8. How long have you had your problem? _____

9. What aggravates your problem?

10. What concerns you the most about your problem; what does it prevent you from doing?

11. What is your: Height _____ **Weight** _____ **Date of Birth** _____

Occupation _____

12. Please indicate any family members with the following diseases:

- Rheumatoid Arthritis Diabetes Lupus Hypothyroid/Hashimotos
 Heart Problems Cancer MS Colitis/IBS

13. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
Only					
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain		
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer		
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

14. List all prescription medications you are currently taking:

15. List all of the over-the-counter medications you are currently taking:

16. List all surgical procedures you have had:

17. Have you ever been hospitalized? No Yes

if yes, why _____

Patient Signature _____ Date: _____

Bovon

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