RESERVED FOR FURTHER COMMENTS

Fatigue Visual Numeric Scale (Please circle your fatigue level in the past 2 weeks)

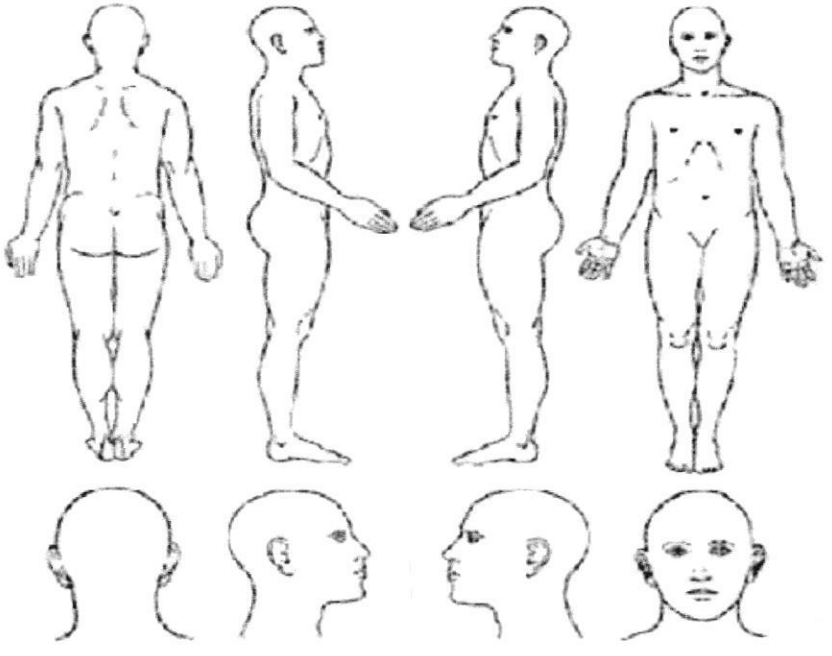
No fatigue 0_____**I**_____**10 Exhaustion**

Visual Pain Scale (Please mark your worst pain level in past 24 hours)

0 ——— **10**

No Pain — **Absolute Worst Pain**

Please use the following body diagrams to indicate any pain (///), numbness (ooo), or tingling (xxx).



Patient Name: _____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES	NO	Diabetes	YES	NO	Cancer
YES	NO	Heart Disease	YES	NO	Alcoholism
YES	NO	High Blood Pressure	YES	NO	Depression
YES	NO	Stroke	YES	NO	Kidney Disease
YES	NO	Inflammatory Arthritis (Rheumatoid, Ankylosing)			

Which of the following medications have you taken in the last week?

	Physician Prescribed	**Not Prescribed by Physician**
Aspirin	YES / NO	YES / NO
Tylenol	YES / NO	YES / NO
Anti-inflamatories (Advil/Motrin/Ibuprofen, Etc.)	YES / NO	YES / NO
Stomach ulcer medications	YES / NO	YES / NO
Vitamins/mineral supplements	YES / NO	YES / NO
Herbals/Other Remedies	YES / NO	YES / NO

Others NOT prescribed by a physician _____

_____

Please list any PRESCRIPTION medication you are currently taking, INCLUDING pills, injections, and/or skin patches.

In the past year I have fallen _____times. Did fall result in an injury? **YES / NO**

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

How many cigarettes do you smoke a day? _____ For how many years? _____ If quit, when? _____

How many days per week do you drink alcohol? _____ How much per day? _____

Please describe your diet and water intake: _____

Specify known *allergies*:_____

Have you recently experienced?:

YES	NO	weight loss/gain	YES	NO	joint/muscle swelling
YES	NO	nausea/vomiting	YES	NO	easy bruising
YES	NO	excessive bleeding	YES	NO	stress at home or work
YES	NO	fatigue	YES	NO	difficulty breathing
YES	NO	weakness	YES	NO	daytime/nighttime cough
YES	NO	fever/chills/sweats	YES	NO	arm/leg swelling
YES	NO	numbness or tingling	YES	NO	heart racing in your chest
YES	NO	tremors	YES	NO	difficulty swallowing
YES	NO	spider/tick/animal bite	YES	NO	heartburn/indigestion
YES	NO	injury	YES	NO	constipation/diarrhea
YES	NO	periodontal /gum disease	YES	NO	blood in stools
YES	NO	dry eyes	YES	NO	post menopause
YES	NO	skin rash	YES	NO	problems urinating
YES	NO	problems sleeping	YES	NO	urinary incontinence/frequency
YES	NO	sexual difficulties	YES	NO	blood in the urine
YES	NO	night sweats	YES	NO	pregnant, or think you might be pregnant

Any architectural barriers or safety issues in your home we should know about? (stairs, steps, slopes, walkways, ...)

Patient name: _____

Leisure Activities: _____

Your current goals: _____

Please circle you present health status: **Excellent** **Very Good** **Fair** **Poor**

What techniques do you use to relax? _____

Please check any of the following whose care you are under: _____**PT** _____ **other:**_____
_____**MD** _____**DO** _____ **Dentist** _____**Chiropractor** _____ **Psychiatrist/Psychologist**

If you have seen any of the above in the last 3 months, please describe reason and care results:

_____

_____

Have you ever been diagnosed as having any of the following? *Check all that apply*

◯ allergies ◯ circulation ◯ Hepatitis/ Liver issues ◯ Parkinson's ◯ rheumatoid arthritis
◯ anemia ◯ currently pregnant ◯ High Cholesterol ◯ Seizures
◯ anxiety ◯ depression ◯ HIV/ AIDS ◯ Smoking
◯ arthritis ◯ diabetes ◯ incontinence (urine) ◯ Speech / swallowing issues
◯ asthma ◯ dizzy spells ◯ incontinence (bowel) ◯ Stroke
◯ autoimmune issues/Thyroid ◯ Kidney issues ◯ TB
◯ bronchitis ◯ emphysema ◯ Lyme/coinfections ◯ vision issues
◯ cancer ◯ fibromyalgia ◯ Metal implants ◯ vestibular issues
◯ cardiac ◯ fractures ◯ MRSA
◯ cardiac pacemaker ◯ gall bladder issues ◯ MS ◯ Mold exposure ◯ Dementia
◯ chemical dependency ◯ headaches ◯ neuropathy
◯ covid/long covid ◯ hearing impairment ◯ Osteoporosis/osteopenia

Please list any surgeries or conditions where you have been hospitalized for same day or overnight procedures:

Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____

Please describe any significant injuries for which you have been treated (including fractures, sprains, dislocations, etc.) and approximate date of injury:

Patient gives permission to discuss medical conditions with another person: YES / NO

Name: _____ Phone: _____