

Personal Information

First Name		Last Name	
Address		City	
State		Zip Code	
Date of Birth		SSN	

Phone Number		2nd Phone Number	
Driver's License #		State Issued	
Email Address			

General Health Information

Circle Yes or No

1. Do you have any allergies?	Yes	No	Comment Section: For any YES answers, please record the item number and list details. Include any surgeries, physicians seen, dates, durations. Please include any physician's seen phone number and address.
2. What Medications are you currently taking (include dosage & frequency) Please answer in comment section.			
3. Do you smoke?	Yes	No	
4. Have you had any surgeries? (Please list dates & procedure)	Yes	No	
5. What medications are you requesting?	List in comments		
6. Have you taken this medication before?	Yes	No	
7. If yes, when did you take it & was it effective?	Yes	No	
8. Have you taken other medications for this condition, if so please list.	Yes	No	
9. What is your chief Medical complaint, please answer in comments section.			
10. Do you have history of:			
a. Anxiety, Depression, or other mental problems?	Yes	No	
b. Kidney Stones	Yes	No	
c. Arthritis, Fibromyalgia, or Joint Pain	Yes	No	
d. Nausea	Yes	No	
e. Stomach ulcers, Intestine, or other digestive problem?	Yes	No	
f. Blood disorders?	Yes	No	
g. Neurological disorders?	Yes	No	
h. Cancer?	Yes	No	
i. Respiratory disorder?	Yes	No	
j. Glaucoma or eye problems?	Yes	No	
k. Sleeping problems?	Yes	No	
l. Heart problems including angina, blood pressure, heart disease, failure, or heart attack?	Yes	No	
m. HIV/AIDS?	Yes	No	
n. Stroke	Yes	No	
o. Thyroid, diabetes, or endocrine disorder?	Yes	No	

11. Where is the Pain, circle one or more:		12. Please indicate where pain is located.	
Neck	Shoulders	Head	Legs
Arms	Lower Back	Upper Back	
13. Describe the Pain:			
Sharp Shooting Dull Localized Electric			
Diffuse Burning Throbbing Steady			
Intermittent Cramping Deep Stabbing			

14. Physical Examination:

Height (In shoes)	Weight	Chest (full inspiration, male only)	Chest (forced expiration, male only)	Abdomen (at umbilicus, male only)
ft. in.	lbs.	in.	in.	in.
15. Blood Pressure (Right arm while seated. Take 2 readings and record, do not disregard any.) If systolic is over 140 or diastolic over 90 take 3 rd and 4 th reading after 10 min. rest.		Sys	Sys	
		Dia	Dia	
		Sys	Sys	
		Dia	Dia	
16. Pulse Rate (at rest). Record for 1 full minute			_____	Irregularities ____/min
17. Did you measure? Yes No		18. Did you weigh? Yes No		

To the best of my knowledge and belief, the answers recorder herein are true and complete

Signature of Patient _____ Date _____

Preferred doctor consultation contact time? Circle One:

8am-11am 11am-2pm 2pm-5pm 5pm-8pm

Signature of Examiner _____ Date _____

Examiner Name	
Examiner Title	
Examiner License Number	
Examiner State	