Medical History Questionnaire

NAME: _____ TODAY'S DATE: _____

AGE: _____ WEIGHT: _____ HEIGHT: _____ OCCUPATION: _____

1. Describe the reason for your visit: _____

   _____

2. Where is your pain? _____
3. When did it start? _____
4. Is your pain the result of an injury? If yes, describe briefly.

   _____

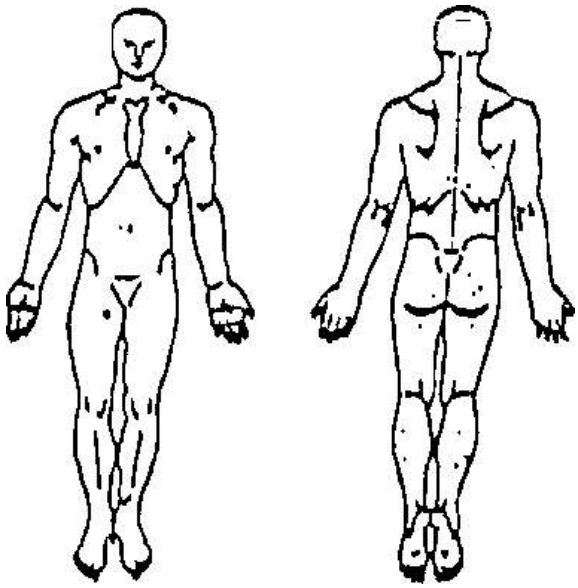
5. Is your pain: constant or intermittent
6. Describe your pain: sharp dull achy deep burning throbbing

   Rank your symptoms from 1-10. (1 being none, and 10 being unbearable)

   At rest: _____ During activities: _____
7. What activities make your pain worse?

   _____

Please draw pain pattern on body chart below:



8. What can you do to relieve your pain? _____
9. Does your condition affect your sleep? Yes or No. If yes, can you go back to sleep? _____
10. How do you feel in the morning? Stiff Sore Fine
11. Since this problem started what tests have been done? X-ray MRI CT Scan Lab work Other: _____

    Dates/Results: _____

    _____
12. Have you had anything similar to this condition (If so, please describe)? _____

    _____
13. List all medications which you are taking: _____

    _____
14. Do you exercise? If yes, please describe: _____
15. Is there anything else that you would like to add? _____

General Medical History

In the last three months have you had any of these symptoms:

_____ fever _____ diarrhea _____ weight loss
_____ fatigue _____ dizziness _____ fainting
_____ nausea _____ vomiting _____ abdominal pain
_____ unexplained sweating

Do you become short of breath easily? Yes or No

Do you experience leg cramps? Yes or No

Do you have headaches? Yes or No
(if so, how often, severity, triggers)

_____

Do you have symptoms before, During, or after eating? Yes or No

Has you bowel or bladder function Changed? (i.e. pain, color, frequency) Yes or No

Are you pregnant? Yes or No

Have you been treated for cancer? Yes or No

Please describe: _____

_____

Do you have chest pain? Yes or No

Are you currently seeing any of the following?

Medical Doctor: Yes or No
Osteopath: Yes or No
Chiropractor: Yes or No
Psychiatrist/
Psychologist: Yes or No
Dentist: Yes or No
Other: _____

If you have seen any of the above during the past three months, please describe for what reason:

_____

_____

Have you had a history of, or do you have the following:

____ Osteopenia / Osteoporosis
____ Kidney Disease
____ Chemical Dependency (i.e. alcoholism)
____ Depression / Anxiety
____ Thyroid Problems Describe: _____
____ Anemia or Hemophilia
____ Diabetes Type: ____ Duration: _____
____ Epilepsy
____ Tuberculosis
____ Hernia
____ Multiple Sclerosis / Parkinson's Disease
____ High Blood Pressure
____ Heart Disease / Problems
____ Pacemaker
____ Bursitis
____ Rheumatoid Arthritis
____ Other arthritic conditions
____ Infection
____ Lung Disease / Respiratory Problems
____ Intestinal (GI) Disorder
____ Liver or Gallbladder Problems
____ Hepatitis
____ Circulatory Problems, Raynaud's, Frostbite, Buerger's Disease, Cold Sensitivity
____ Stroke: _____
____ Other: _____

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains, falls), and any surgeries or other conditions for which you have been hospitalized:

DATE:	PROBLEM:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____