Dr. Sarah N. Kirsch
Dr. Ashley Rich

*Problem #*____________
New Dx (Y / N)
X-Ray (Y / N)

PATIENT NAME: ____ DATE: ____________

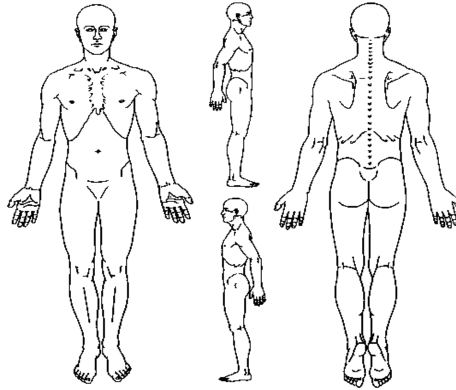
Subjective: [ ] First Visit [ ] Re-exam [ ] New Complaint [ ] Counsel/Care Coordination

Please draw the location of your symptom and use the letters in the key box below to describe your symptom

Please list your complaint(s) in order of importance and rate it on the pain scale

(least) *(worst)*

1. ________________ 1 2 3 4 5 6 7 8 9 10
2. ________________ 1 2 3 4 5 6 7 8 9 10
3. ________________ 1 2 3 4 5 6 7 8 9 10
4. 1 2 3 4 5 6 7 8 9 10



Key	
P	Pain [ ] Dull [ ] Pinching [ ] Sharp [ ] Stabbing
A	Aching
B	Burning
N	Numbness
T	Tingling
S	Stiffness

What is the cause of your symptom(s)?
[ ] Specific Injury [ ] Unknown [ ] Repetitive Stress [ ] May be Related to [ ] Other

____
____
____

Have you seen anyone for this condition before? [ ] No [ ] Yes (If yes, please answer the following questions)

Who? ____
When? ____
What type of treatment did you receive? ______________________________
Was the treatment beneficial? ______________________________
Did you receive any prescriptions? (If yes, please list the medication)
[ ] No [ ] Yes______________________________
Were any X-rays or advanced images (MRI, CT) taken? (If yes, please ask for a copy of the report or films)
[ ] No [ ] Yes______________________________

Have you used any of the following to treat your condition, and did they help? [ ] No [ ] Yes

[ ] Non-prescription drugs? ______________________________
[ ] Vitamins/Botanicals______________________________

When did this problem begin? Approximately __________ (Hours Days Weeks Months Years) ago.

If there was a specific injury, did the pain begin [ ] Immediately [ ] Hours after [ ] Days after [ ] Weeks after

____

What makes it better? ____

____

What makes it worse? ____

____

Pain Scale On a scale of 0-10 (0 being no pain, 10 being the worst pain imaginable) how do you rate your pain?

_____/10 (Right now) _____/10 (At its worst) _____/10 (At its best)

Does the pain radiate (or move) from its original location?

[ ]No [ ]Yes (*describe where*)______________________________

Associated Symptoms

[ ]None [ ]Yes______________________________

Timing *Has your complaint(s) become better or worse since the initial onset?*

[ ]Better [ ]Worse ______________________________
Does your complaint(s) change throughout the day? [ ] No [ ] Yes (please describe below)

____

Activities of Daily Living (Difficulties) *i.e. Sitting, Walking, Changing Position, Brushing Teeth, etc…*

[ ]None [ ]Yes ______________________________

Patient # ____________ CA initials_____

Patient Name: ___________________

Confidential Health History

Date: ___________________

*In the space provided, please place a "**P**" if you presently have the problem or an "**H**" if you've had the problem in the past*

General

1 ____ Fever
2 ____ Chills
3 ____ Night Sweats
4 ____ Loss of Sleep
5 ____ Fatigue
6 ____ Stress
7 ____ Nervousness
8 ____ Weight Loss or Gain
9 ____ Allergies
10____ Bleeding Problems
11 ____ Anemia
12 ____ Diabetes
13 ____ Cancer
14 ____ Thyroid Disease
15 ____ Alcoholism
16 ____ Drug Abuse
17 ____ Other

Women Only

51____ Date Last Period Began ____/____/____
52 ____Date of last OB/GYN exam ____/____/_____
53 ____Date of last Mammogram ____/____/_____
54 ____ Painful Periods
55 ____ Excessive Flow
56 ____ Irregular Cycles
57 ____ Infections
58 ____ Hot Flashes
59 ____ Live Births #____ (Normal/C-section)
60 ____ Miscarriage
61 ____ Other ___________________________

Men Only

62 ____ Testicular Swelling
63 ____ Testicular Pain
64 ____ Prostate Problems
65 ____ Other

Musculoskeletal

96 ____ Neck Stiffness
97 ____ Neck Pain
98 ____ Pain between Shoulders
99 ____ Low Back Pain
100____ Swollen Joints
101 ____ Painful Joints
102 ____ Muscle Aches/Soreness
103 ____ Spinal Curvature
104 ____ Arthritis
105 ____ Other

Accidents/Trauma

106 ____ Motor Vehicle Accidents (List Dates, Severity & Type of Collisions) ____
____
107 ____ Other Trauma/Accidents ______________________
____

Respiratory

18 ____ Difficult Breathing
19____ Chronic Cough
20 ____ Wheezing/Asthma
21 ____ Pneumonia
22 ____ Tuberculosis
23 ____ Other

Cardiovascular

66 ____ High Blood Pressure
67 ____ Previous Heart Trouble
68 ____ Ankle Swelling
69 ____ Varicose Veins
70 ____ Rheumatic Fever
71 ____ Stroke
72 ____ Other

Hopitalizations

108 ____ List Dates & Reasons ________________________
____
____

Surgeries

109 ____ List Dates & Reasons ________________________
____
____

Eye Ear Nose Throat

24 ____ Poor Vision
25 ____ Deafness/Difficulty Hearing
26 ____ Nose Problems
27 ____ Sinus Trouble
28 ____ Dental Problems
29 ____ Hoarseness
30 ____ Other

GU

73 ____ Frequent Urination
74 ____ Painful Urination
75 ____ Blood in Urine
76 ____ Kidney Disease
77 ____ Kidney Stones
78 ____ Urinary Infection
79 ____ Inability to Control Urination
80 ____ Difficulty Starting Urine Flow
81 ____ Other

Family History

110 ____ Diabetes
111 ____ Thyroid Disease
112 ____ Kidney Disease
113 ____ High Blood Pressure
114 ____ Heart Disease
115 ____ Cancer
116 ____ Muscle, Bone or Nerve Disease
117 ____ Other

GI

31 ____ Poor Appetite
32 ____ Poor Digestion
33 ____ Difficulty Swallowing
34 ____ Belching or Gas
35 ____ Heartburn
36 ____ Frequent Nausea
37 ____ Vomiting
38 ____ Abdominal Pain
39 ____ Ulcer
40 ____ Black or Bloody Stools
41 ____ Loss of Bowel Control
42 ____ Liver Problems
43 ____ Gall Bladder Problems
44 ____ Jaundice
45 ____ Hernia
46 ____ Diarrhea
47 ____ Constipation
48 ____ Hemorrhoids
49 ____ Appendicitis
50 ____ Other

Neurologic

82 ____ Weakness
83 ____ Twitching
84 ____ Tremors
85 ____ Headaches/Migraines
86 ____ Fainting
87 ____ Dizziness
88 ____ Convulsions
89 ____ Epilepsy
90 ____ Numbness/Tingling
91 ____ Arm Pain
92 ____ Leg Pain
93 ____ Mental Disorders
94 ____ Muscular Disorders
95 ____ Other
96 List ALL MEDICATIONS HERE

Habits

118 ____ Recreational Drug Use
119 ____ Smoking ____ Packs/Day
120 Alcoholic Beverages/Week (please circle ~amt)
NONE / MILD / MODERATE / EXCESSIVE
Wine / Beer / Liquor

Exercise

	<u>If yes, circle below</u>
121 ____ None	
122 ____ 1-2 times/week	Cardio/Aerobics
123 ____ 3-5 times/week	Weight Lifting
124 ____ 6-7 times/week	Yoga / Pilates

Nutritional Status

125 How is your diet in general (please circle)?
EXCELLENT / GOOD / FAIR / POOR

126 How is your health in general (please circle)?
EXCELLENT / GOOD / FAIR / POOR

**Please list ALL current medications:

Patient # _____________ DC initials_____