Health Center at Touro University Nevada
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Date: _____

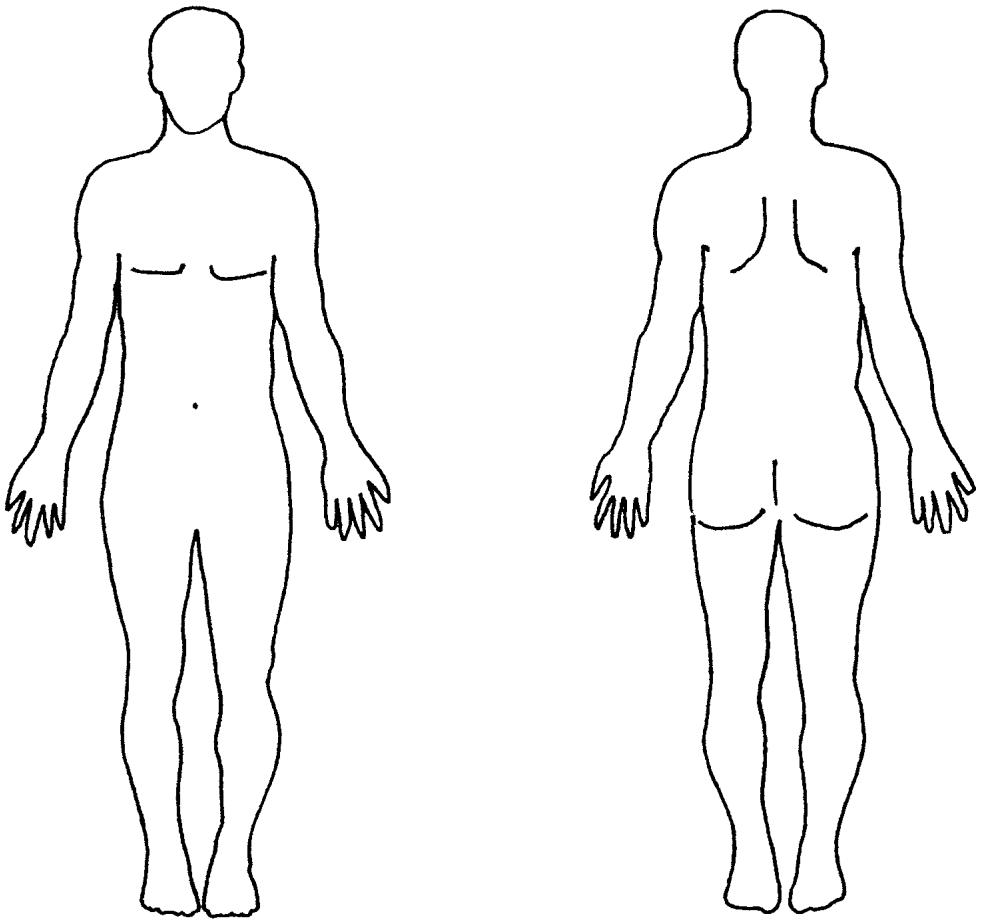
Name: _____ DOB: _____ Sex: M__ F__

Chief Complaint (Reason for Visit):_____
History of Present Illness: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Pain Diagram: Mark the areas of your body where you feel the described sensations:

Ache	Numbness	Pins and Needles	Burning	Stabbing
AAAA	OOOOOO	==========	XXXXX	//////////////

Right Left Left Right



What makes your pain worse? _____
What makes your pain better? _____

What time of day is your pain the worst? Awakening__Mid-morning__Mid-day__ Afternoon__
Evening__Bedtime__Have pain 24 hours a day__.
What time of day is your pain better? Awakening__Mid-morning__Mid-day__ Afternoon__
Evening__Bedtime__Do not normally have pain__.

On a scale of 1 to 10 please circle your pain level. Currently 0--1---2—3—4—5—6—7—8—9—10
What is your worst pain? 0--1---2—3—4—5—6—7—8—9—10
What is your pain at its best? 0--1---2—3—4—5—6—7—8—9—10

Do you exercise on a regular basis? Describe: _____

Have you had tests for this condition? If so, when? Regular X-rays _____
CT (CAT Scan) _____MRI _____
Nerve Test (EMG) _____Other: _____

Current medications (all, including for this condition)_____
_____
_____
_____
_____

Allergies: Please list all allergies: Medications: _____
_____
Environmental allergies: (dust, pollen, mold) _____

Have you received treatment for this condition previous to this visit? (Chiropractic, Pain Clinic, OMT, PT, etc.)
_____
_____
_____
_____

Past Medical History:
Please mark below any of the medical conditions with which you have been diagnosed. Please list any others not included here. Diabetes___ High blood pressure___Heart trouble__Stroke__ Lung disease__Arthritis__ Back or neck problems__TMJ or dental problems__Headaches__Depression____ Others or explain positives:
_____
_____
_____

Please list any surgery that you have had and the approximate date (year): _____
_____
_____
_____

Please list all trauma you have had, including falls, motor vehicle accidents, fractures, etc., and how long ago (date)._____
_____
_____

Family and Social History:
Mother: Alive-age ___in good health __Medical conditions _____Deceased __age__

Father: Alive-age__ _in good health __Medical conditions _____Deceased __age__

I have ___Brothers and ___Sisters __in good health __Medical conditions (see below) Deceased __age(s) ____

Members of my family (brothers, sisters, grandparents, aunts, uncles) have the following diseases. Please indicate who has disease. None __Diabetes _____High blood pressure_____
Heart trouble _____ Stroke _____Lung disease _____Arthritis_____
Kidney disease _____Genetic or inherited disease _____Other:_____

Social History:
Married __Separated __Divorced __Widowed __Single. Number of children ____at home ___away ____

Occupation: _____retired ____years retired ___Education level _____

Do you have a balanced diet? Breakfast_____Lunch_____Dinner_____Snacks_____.
Do you drink alcohol? No ___Yes ___Bee r ___Wine ___"hard drinks"___ Number per day/wk/mos. _____.
Do you drink caffeinated drinks? No__ Yes __ coffee __ tea __ soda pop __ energy drinks ___How many? ___.
Do you use tobacco? Yes__cigarette__cigar___pipe___smokeless___Number per day/wk/mos_____ No__.

Do you sleep well at night? Yes__avg. number of hours___ Do you have trouble falling asleep? __ trouble staying asleep? ___Do you awaken early? ___Do you snore?____ Have you been diagnosed with sleep apnea?

Review of systems:
General: Have you experienced any of the following the past year? Explain if needed.
Weight loss ____Weight gain____ Explain_____ No __.
Intolerance to heat ___Intolerance to cold __Explain_____ No __.
Increase in fatigue__Explain_____ No __.
Increase in appetite __Decrease in appetite__ Explain _____ No __.
Any unusual fever, chills or sweats __Explain _____ No __.

Head, Eyes, Ears, Nose and Throat:
Headaches? Yes __ New? __ Explain_____ No__.
Dizzy or Lightheaded? Yes __ New? __ Explain _____ No __.
Problems with eyes? Blurry vision __Double vision __light sensitivity __Explain _____ No__.
Do you wear glasses __ or contact lens __? Any recent change in vision? _____ No __.
Do you have problems with your hearing? Yes __ Pain __ Ringing ___Buzzing __Decreased hearing__ No__.
Have you had a history of sinusitis? Yes__ Decreased sense of smell? Yes__ Dry__ or runny nose___? No __.
Pain in your face around your nose and/or eyes? Yes __ Explain _____ No __.
Do you have tooth pain __ or mouth sores __? Do you wear dentures or partials? Yes __ No __.
Do you have clicking or popping of the jaw? Yes __ Have you had braces? Yes __ Extractions? Yes __ No__.

Respiratory:
Do you have any problems with your lungs? Yes __ Explain_____ No__.
Do you have difficulty breathing? With exertion__ laying flat __ Explain _____ No __
Do you have a chronic or persistent cough? Yes __ Explain _____ No __.

Cardiac:
Have you ever had chest pain associated with your heart? Yes __ Explain _____ No __

Have you ever had irregular or extra heart beats? Yes __ Explain_____ No__.
Do you have chest pain with arm or shoulder movement? Yes __ Explain _____ No __.

Gastrointestinal:
Do you have problems with your stomach or bowels? Yes __ Explain _____ No __.
Do you have problems with diarrhea __ constipation __ vomiting __ nausea __ indigestion (reflux)? __ No __.
Have you ever vomited blood or had bloody bowel movements? Yes __ Explain _____ No __
Do you have trouble swallowing? Yes __ bloating or gas? Yes __ certain foods bother you? Yes ___ No __.
Explain _____.

Urinary:
Do you have problems with your bladder? Yes __ trouble starting _____ stopping _____ holding _____ No __.
Do you have urinary frequency? __ Urgency __ burning __. History of kidney stones? Yes __ when ___ No __.

Sexual/Genital:
Do you have a loss of sexual desire? Yes __ Loss of sexual ability? __ Performance __ No __.
Men: Do you have problems with your prostate? Yes __ Explain _____ No __.
Women: Do you have problems with your uterus/ovaries? Yes __ Explain _____ No __.
How many times have you been pregnant? ___ Delivered ___ C-section ____Lost _____ none ___.
Do you still have menstrual periods? Yes __ normal__ not normal __ explain _____No__.

Musculoskeletal: If not covered in History of Present Illness.
Do you have new or different back or neck pain? Yes __ head __ neck__ back__ extremities _____No __.
Do you have numbness or tingling in your neck, back or extremities? Yes __ explain _____No __.
Do you have specific muscle pain__ or tremors __? Explain _____ No __.
Do you have trouble walking __ or using your arms/hands__? Explain _____ No __.
Do you have joint pain __ swelling __ redness __ stiffness __? Explain _____ No __.
Has your pain affected your ability to function? Yes __ Explain _____ No __.
Do you have restless leg syndrome? Yes __ medication? _____ No__.
Does leg pain wake you up at night? Yes __ Explain _____No__.

Neurological/Psychological: _____
Do you have loss of balance___ trouble maintaining balance ___spinning sensation? _____ No __.
Have you ever had a seizure? Yes__ Explain _____ No __.
Do you have trouble concentrating__ or remembering? __ New? __ Explain _____ No __.
Do you have trouble with anxiety__ nervousness __ depression? ___ Explain _____ No __.

Signature _____ Date _____