HEALTH PROFILE FORM PRINT PATIENT NAME: _____

Describe your symptoms: _____

_____Date symptoms first appeared: ___/___/___

SEVERITY OF PAIN & SYMPTOMS: Chief Complaints (Major Complaints)

CC1: _____CC2: _____

CC3: _____CC4: _____

1 – What is your pain RIGHT NOW?
No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?
No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?
No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?
No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

What percent of the time do you experience these symptoms? □100% □75% □50% □25% □10%

Did it begin: □Gradually □Suddenly □Progressed over time? Other: _____

Are your symptoms a result of: □Motor Vehicle Accident □Work related Accident □Other_____

What makes your symptoms worse? _____

_____

What improves your symptoms? _____

_____

Quality of pain: □Dull □Achy □Sharp □Stabbing □Burning □Throbbing □Electrical □Other _____

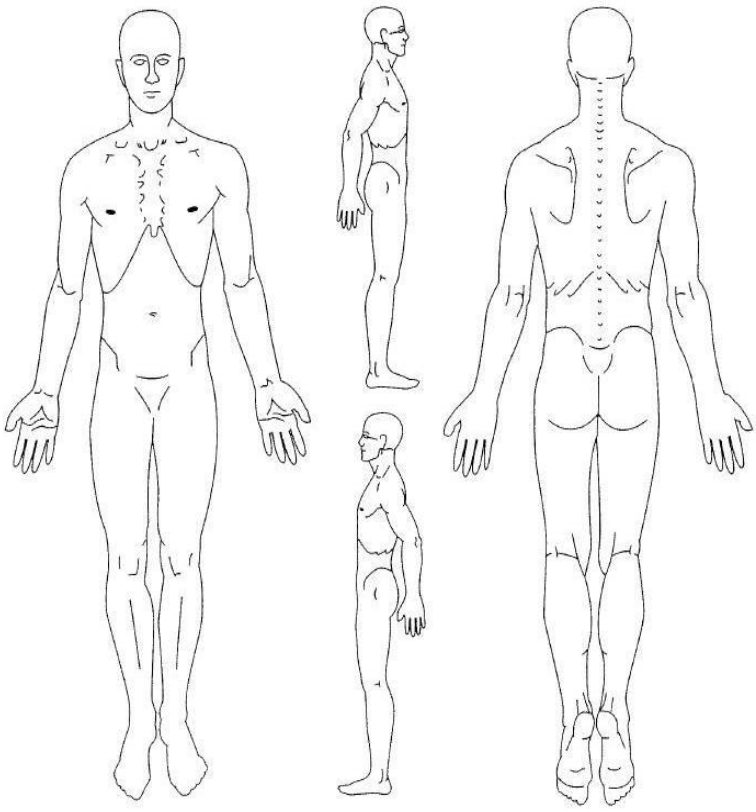
Does the pain radiate into your: □**R** Arm □**L** Arm □**R** Hand □**L** Hand □**R** Shoulder □**L** Shoulder
□**R** Leg □**L** Leg □**R** Hip □**L** Hip □**R** Foot □**L** Foot □Head □Other _____ □Does Not Radiate?
Do you experience numbness or tingling? □**R** Arm □**L** Arm □**R** Hand □**L** Hand □**R** Shoulder □**L** Shoulder
□**R** Leg □**L** Leg □**R** Hip □**L** Hip □**R** Foot □**L** Foot □Head □Other _____ □No numbness or tingaling?

What have you already tried to resolve this problem: (check all that apply?)
□Over The Counter Drugs □Prescription Strength Drugs □Physical Therapy □Surgery
□Chiropractic □Massage Therapy □Acupuncture □Nutritional Supplements
□other: _____

PATIENT SIGNATURE _____ DATE _____

LOCATION OF SYMPTOMS: Please indicate any areas of discomfort or pain on the body chart below. Mark the areas where you feel the described sensations using the following symbols. Please include all affected areas and mark areas of radiation (traveling pain).

Pain = P Tingling = T
Numbness = N Cramping = C
Burning = B Radiating Pain = R



Activities of Daily Living Assessment:

Rate your current difficulties by placing the appropriate number in the box.
[0] Does not cause pain or does not effect an activity
[1] Activity causes some pain or minor annoyance.
[2] This activity causes a significant amount of pain.
[3] Cannot perform activity due to pain and disability.

Self Care and Personal Hygiene

____bathing ____brushing teeth ____putting on shoes ____doing laundry ____ grooming hair
____making bed ____putting on pants ____doing dishes ____washing face ____putting on shirt
____cooking ____taking out trash ____going to bathroom or sitting on toilet

Physical Activities

____standing ____walking ____reaching ____bending right ____twisting right ____sitting
____squatting ____bending ____bending left ____twisting left ____reclining ____bending back
____kneeling ____looking left ____looking right

Functional Activities

____carrying small objects ____lifting weight off table ____push/pull standing
____carrying large objects ____climbing stairs/incline ____exercising upper body
____exercising lower body ____carrying purse/case ____lifting objects off floor
____push/pull seated

Social & Recreational Activities

____jogging ____biking ____swimming ____dancing ____golfing ____bowling ____hunting
____fishing ____gardening ____basketball ____soccer ____hockey ____competitive sports

Difficulties with Travel

___driving in car ____riding as passenger ____entering and exiting vehicle
____driving for long periods of time ____riding as passenger for long period of time

Other Activities

____concentrateing ____studying ____listening ____reading ____writing ____using computer
____sleeping ____sexual relation

PATIENT SIGNATURE _____ DATE _____

MEDICAL HISTORY: Height: _____ Weight: _____ BP: ____/____ Temp: _____ Pulse: _____ Resp.: _____

Surgeries: (Check all that apply to you)

□ Appendectomy	□ Cardiovascular procedure	□Cervical spine	□ Hysterectomy
□ Joint Replacement	□ Prostate	□ Lumbar spine	□ Gall Bladder
□ Brain	□ Shoulder	□ Thoracic spine	□ Knee
□ Carpal Tunnel	□ Gastro-intestinal	□ Uro-genital	□ Hernia

□Breast Augmentation □ Other _____

Allergies: (Check all that apply to you)

□ Medication _____ □ Other _____

□ Mold □ Seasonal □ Milk or Lactose □ Animal □ Sulfites □ Wheat/Glutens

List all Hospitalizations: _____

List all Past accidents: _____

List all Medications and Supplements: _____

_____

Social History: (Check all that apply to you)

Caffeine use:	□ occasional	□ often	□ never	□ Other: _____
Drink Alcohol:	□ occasional	□ often	□ never	□ Other: _____
Exercise:	□ occasional	□ often	□ never	□ Other: _____
Drink Water:	□≤64 oz/day	□>64 oz/day	□ never	□ Other: _____
Cigarettes:	□≤1 pack/day	□ >1 pack/day	□ never	□ Other: _____
Sleep:	□≤8 hrs/night	□ >8 hrs/night	□ Insomnia	□ Other: _____

How would you rate your diet? Poor □1 □2 □3 □4 □5 Excellent

How would you rate your overall energy? Poor □1 □2 □3 □4 □5 Excellent

How would you rate your stress levels? Low □1 □2 □3 □4 □5 High

Describe your social activity: _____

_____

Family History: (Check all that apply)

Arthritis:	□ Parent	□ Sibling	Cancer:	□ Parent	□ Sibling
Diabetes:	□ Parent	□ Sibling	Heart Disease:	□ Parent	□ Sibling
Hypertension:	□ Parent	□ Sibling	Stroke:	□ Parent	□ Sibling
Thyroid:	□ Parent	□ Sibling			

Other: _____

Other Important Health Information: _____

_____

_____

_____

PATIENT SIGNATURE _____ DATE _____

Review of Systems *(Check box if you have had trouble with any of the following)*

GENERAL
- □Leathergy/ Weakness
- □Recurring Fever
- □Recent weight loss or gain
- □Dizziness
- □Fever
- □Chills

HEENT
- □Headaches Migraines
- □Eye/Visual Problems
- □Eyeglasses/contact
- □Nose bleeds
- □Eye surgery
- □Cataracts
- □Glaucoma
- □Sore throat
- □Hoarseness
- □Swollen glands
- □sinus trouble congestion
- □Ear/hearing problems
- □Dental problems
- □Gum problems
- □TMJ problems
- □Postnasal drip

SKIN / HAIR
- □Skin trouble rashes
- □Flushing
- □Excessive acne
- □Eczema
- □Psoriasis
- □Skin cancer
- □ Issues skin pigmentation
- □Change hair/nails
- □Blood in stool
- □Easy bruising
- □Gum bleeding

CARDIOVASCULAR
- □Chest pain
- □Heart attack
- □Shortness/breath
- □Palpitations
- □Swelling feet/hands
- □High blood pressure
- □High cholesterol
- □Heart murmur
- □Blood clots
- □Pacemaker
- □Mitral valve Prolapse
- □Congenital heart defects
- □Rheumatic fever
- □Leg pain upon walking
- □Varicose veins
- □Dizziness
- □Excessive bruising
- □Coronary artery disease

RESPIRATORY
- □Persistent cough
- □Spitting up blood
- □Asthma/wheezing
- □Shortness of breath
- □Exercise intolerance
- □Sleep apnea
- □Emphysema
- □Snoring issues
- □Tuberculosis
- □Pneumonia
- □Breathing
- □Hay fever

GASTROINTESTINAL
- □Loss of appetite
- □Nausea/vomiting
- □Diarrhea
- □Constipation
- □Abdominal pain
- □Stomach ulcer
- □Bloating/Cramping
- □Heartburn
- □Hemorrhoids
- □Hepatitis
- □Cirrhosis
- □Difficulty Swallowing
- □Jaundice
- □Liver disease
- □Gallbladder
- □Pancreatitis
- □Change in bowel habits
- □Black/bloody stool
- □Colon cancer/polyps
- □ Food sensitivities
- □Irritable bowel syndrome
- □Crohn's disease
- □Gastric reflux
- □Collitis

NEUROLOGICAL
- □Frequent headaches
- □Migraines
- □Dizziness
- □Fainting
- □Memory loss
- □Poor balance
- □Numbness/tingling
- □Pins/needles
- □Seizures/Epilepsy
- □Stroke
- □Tremors
- □Head injury
- □Anxiety/panic
- □Depression
- □Sleeping issues
- □Weak muscles
- □Loss smell/taste
- □Temporary vision loss
- □Difficulty concentrating

MUSCULOSKELETAL
- □Arthritis
- □Joint pain/Swelling
- □Neck pain
- □Back pain
- □Trauma
- □Osteoporosis
- □Scoliosis
- □Cramping
- □Fractures
- □Implants/plates pins/screws
- □ Hip disorders
- □ Knee injuries
- □Foot/ankle pain
- □Shoulder problems
- □Elbow/wrist pain
- □Poor posture
- □Gout

BLOOD / LYMPH
- □Anemia
- □Bleeding
- □Bruising
- □Blood clots
- □Transfusions
- □Leukemia
- □Lymphoma
- □HIV/AIDS
- □Sickle cell

PSYCHIATRIC
- □Alzheimer's
- □Insomnia
- □Difficulty concentrating
- □Memory loss/ confusion
- □Depression
- □Anxiety
- □Agitation/ Irritability
- □Suicidal thoughts
- □Chemical dependency

ENDOCRINE
- □Diabetes
- □Thyroid
- □Sweating
- □Heat intolerant
- □Cold intolerant
- □Weight loss
- □Weight gain
- □Frequent urination
- □Excessive thirst
- □ Appetite Change
- □Hair changes

URINARY
- □Frequent/Painful urination
- □Incontinence
- □Hesitancy
- □Urgency
- □Blood in urine
- □Kidney stones
- □Urinary infections
- □Genital/bladder/ urinary complaints

MALE
- □Dribbling
- □Loss of libido
- □Erectile dysfunction
- □STD
- □Testicular pain/lumps
- □Prostate disease
- □Penile discharge

FEMALE
- □Painful Sex
- □Vaginal discharge
- □Breast Pain/ Lumps
- □Hot Flashes
- □Menstrual irregularity
- □Loss of libido
- □Menopause
- □STD

Pregnant Now?
□**Y** □**N**
Date of Last Cycle
□N/A
____/____/___

PATIENT SIGNATURE _____ DATE _____