MEDICAL HISTORY: Please check all that apply.

[ ] Stroke [ ] Heart Attack [ ] High blood pressure [ ] COPD/asthma [ ] Blood clots
[ ] Coronary artery disease [ ] Peripheral vascular disease/circulation problems
[ ] Diabetes [ ] Kidney disease [ ] Hepatitis [ ] Thyroid disease [ ] Cancer
[ ] Coagulation disorder [ ] Gastritis/ulcers/reflux [ ] Psychiatric treatments [ ] HIV/AIDS
[ ] Left hand dominant [ ] Right hand dominant
[ ]Other:_____

PAST SURGERIES OR HOSPITALIZATIONS (and year): _____

_____

SOCIAL HISTORY:

Occupation:_____[ ]Full time [ ] Part time [ ] Retired [ ] Not working [ ] Disability
Marital Status: **S M D W** Sep # of Children:_____
Do you have a history of drug or alcohol abuse/dependency? [ ]Yes [ ] No
Tobacco use: [ ]No [ ] Yes _____Pack per day_____Years [ ] Former smoker
Alcohol use: [ ]No [ ] Yes _____drinks per week

FAMILY HISTORY- (Please circle yes or no)

Diabetes	Y	N	Cancer	Y	N
High blood pressure	Y	N	Lupus	Y	N
Heart disease	Y	N	Rheumatoid Arthritis	Y	N
Stroke	Y	N	Fibromyalgia	Y	N

AT THE PRESENT TIME ARE YOU EXPERIENCING PROBLEMS WITH:

Constitutional: [ ] fever [ ] chills [ ] sweats [ ] weight loss [ ] weight gain [ ] sleepiness [ ] fatigue

Eyes, Ears, Nose, Mouth, Throat: [ ] blurry vision [ ] double vision [ ] blind spots [ ] trouble chewing [ ] choking [ ] dry mouth

Cardiovascular: [ ] palpitations [ ] chest pain [ ] fainting

Respiratory: [ ] wheezing [ ] coughing [ ] shortness of breath

Gastrointestinal: [ ] heartburn [ ] nausea [ ] vomiting [ ] constipation [ ] diarrhea

Genitourinary: [ ] incontinence [ ] frequency [ ] hesitancy [ ] painful urination [ ] blood in urine

Neurological: [ ] numbness [ ] tingling [ ] balance difficulties [ ] spasms [ ] burning

Musculoskeletal: [ ] global weakness or myalgia [ ] focal weakness [ ] joint pain and swelling [ ] neck pain [ ] back pain

Psychiatric: [ ] anxiety [ ] depression [ ] suicidal thoughts or attempts [ ] insomnia [ ] memory issues

Endocrine: [ ] excessive thirst [ ] hair loss [ ] sexual problems

Inegumentary: [ ] skin rashes [ ] eczema

Patient Signature:_____ Date:_____