

New Patient Form

What is your major complaint? _____

Start date: _____ Possible cause: _____

Symptoms _____ Previous doctors seen for complain: _____

Previous treatment: _____

Symptoms- Aggravating factors: _____

Symptoms- Relieving facors: _____

Time of day symptoms are best: _____

Current duration of pain: (Circle best described) Intermittent Constant With certain motions

How long have you had the pain? _____

Is your pain getting better or worse? YES or NO Have you had this injury before? YES or NO

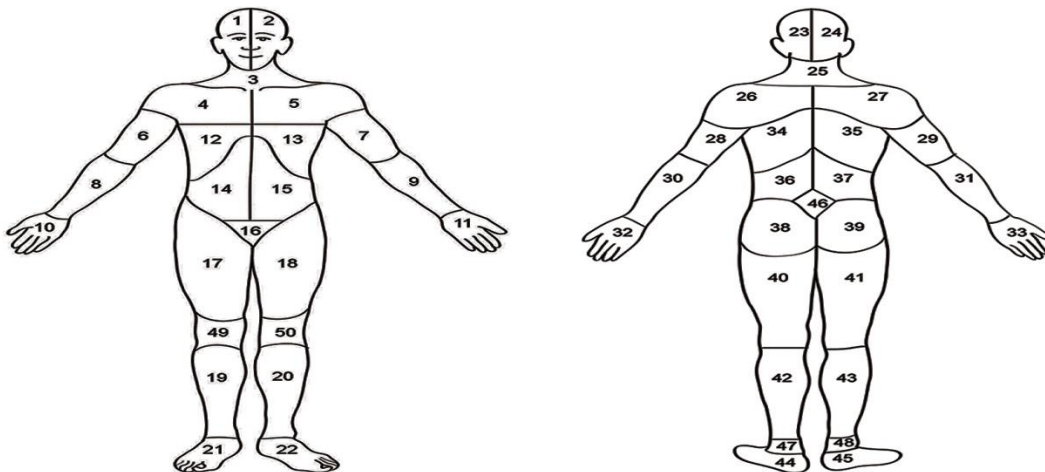
Rate your pain 0-10 (0=no pain, 10= worst pain) circle ONE

Level of pain at its WORST: 1 2 3 4 5 6 7 8 9 10

Level of pain at its BEST: 1 2 3 4 5 6 7 8 9 10

Level of pain at its Average: 1 2 3 4 5 6 7 8 9 10

Circle the areas of discomfort



What other methods of pain have you used in the past? _____

Do you have any of the following? (Circle all that apply)

AIDS/HIV	ANEMIA	ANGINA	ARTERIOSCLEROSIS
ARTHRITIS	ASTHMA	BLOOD CLOTS	BONE INFECTION
CANCER	CHEMICAL DEPENDENCY	CIRCULATION PROBLEMS	DEPRESSION
DIABETES	EPILEPSY	EYE INFECTION	HEART PROBLEM
HEROPHILIA	HIGH/LOW BLOOD PRESSURE	JOINT/ BONE INFECTION	LIVER PROBLEM
LUNG ISSUES	MULTIPLE SCLEROSIS	MUSCULOSKELETAL PROBLEMS	PNEUMONIA
STROKE	STD	TUBERCULOSIS	URINARY INFECTION

Pasted Medical History

Asthma	Liver cirrhosis	Hepatitis B	Hepatitis C
Seizures	Hiv/aids	Diabetes	Arthritis
Migraines	High blood pressure	Pancreatitis	Obesity
Anemia	Stroke	Heart failure	Tuberculosis
Liver disease	Sleep apnea	Cancer	Lupus
Anorexia/ Bulimia	Schizophrenia	Scleroderma	Endometriosis
Kidney failure	Gastric reflux	Osteoarthritis	Ankylosing spondylitis
COPD/ Emphysema	Ovarian cyst	Bleeding Disorder	Irritable Bowel Syndrome
Kidney Stones	Blood Clots in legs	Heart Attack	Other: _____ _____

Surgical History

- | | |
|--------------------------------------|---------------------------------------|
| 1. _____
(Month/Year) (Procedure) | 6. _____
(Month/Year) (Procedure) |
| 2. _____
(Month/Year) (Procedure) | 7. _____
(Month/Year) (Procedure) |
| 3. _____
(Month/Year) (Procedure) | 8. _____
(Month/Year) (Procedure) |
| 4. _____
(Month/Year) (Procedure) | 9. _____
(Month/Year) (Procedure) |
| 5. _____
(Month/Year) (Procedure) | 10. _____
(Month/Year) (Procedure) |

X: _____
Signature

Today's Date: ____/____/____