TELL US ABOUT YOU

THIS FORM MUST BE COMPLTED FOR YOUR RECORD

What is the reason for your visit today?_____

How long as it bothered you? _____

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

(**Circle your pain level**: 0 – being no pain - 10- being unbearable)

Does anything make your pain better? _____

Have you had any prior treatment by a doctor? _____

Height:_____ **Weight:_____** **Shoe Size:**

Smoking/Tobacco Use: Current Past Never **Type:_____** **Amount/day:_____** **Number of years:**

Recreational Drug Use: Current Never **Type:_____** **Number of years:_____**

Alcohol Use: Current Never **Frequency:_____**

PLEASE LIST ALL PRIOR SURGERIES

_____

_____

_____

ALLERGIES to Medications: _____

Please CIRCLE any of the listed medical conditions that pertain to your health.

AIDS	**Dementia**	**Liver Disease**
Alzheimer's	**Depression**	**Neuropathy**
Anemia	**Diabetes (Type_____)**	**Osteopenia/Osteoporosis**
Anxiety	**Eye Problems**	**Parkinson's Disease**
Arrhythmia:Irregular Heartbeat	**Fibromyalgia**	**Peripheral Vascular Disease (PVD)**
Arthritis_____	**Gout**	**Seizures**
Asthma	**Heart Disease**	**Stroke**
Back Pain/Problems	**Hepatitis (Type_____)**	**Thyroid Disorder**
Bipolar Disorders	**High Blood Pressure**	**Tuberculosis**
Bleeding Disorders	**High Cholesterol**	**Other:_____**
Cancer_____	**HIV**	
COPD	**Kidney Disease**	