

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ 2017

Please describe your symptoms/conditions using the outline below. Pick your symptoms/conditions by listing the most serious ones first. If you have more than two problems you can list them at the bottom according to severity. Dr. Falentin will address them in the future.

**1<sup>st</sup> Condition/Symptom**

Describe your symptom: \_\_\_\_\_ When did it start: \_\_\_\_\_

How did it start: \_\_\_\_\_

How often do you experience your symptom?

- ① **constantly** (76-100% of the day)
- ② **Frequently** (51-75% of the day)
- ③ **Intermittently** (26-50% of the day)
- ④ **Occasionally** (0-25% of the day)

Describe the nature of your symptom:

- ① **Sharp** ② **Dull ache** ③ **Numb**
- ④ **Shooting** ⑤ **Burning** ⑥ **Tingling**

How is your symptom changing?

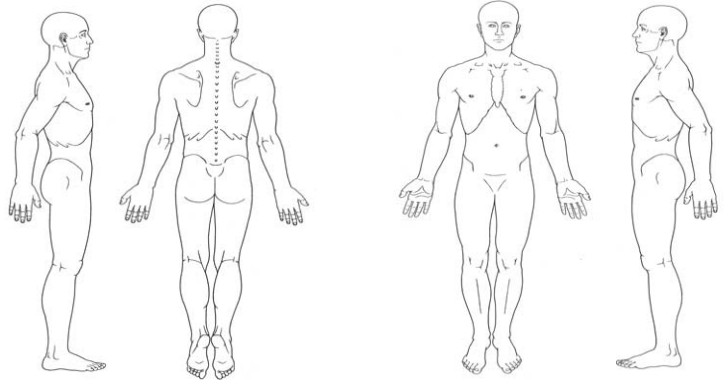
- ① **Getting better** ② **Not changing** ③ **Getting worse**

Choose your least and your worst pain rating:      0 1 2 3 4 5 6 7 8 9 10

Choose your pain at this moment:                      0 1 2 3 4 5 6 7 8 9 10

How much has pain interfered with work?      1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

How much is your condition interfering with your social activities?      1 2 3 4 5



**2<sup>nd</sup> Condition/Symptom**

Describe your symptom: \_\_\_\_\_ When did it start: \_\_\_\_\_

How did it start: \_\_\_\_\_

How often do you experience your symptom?

- ① **constantly** (76-100% of the day)
- ② **Frequently** (51-75% of the day)
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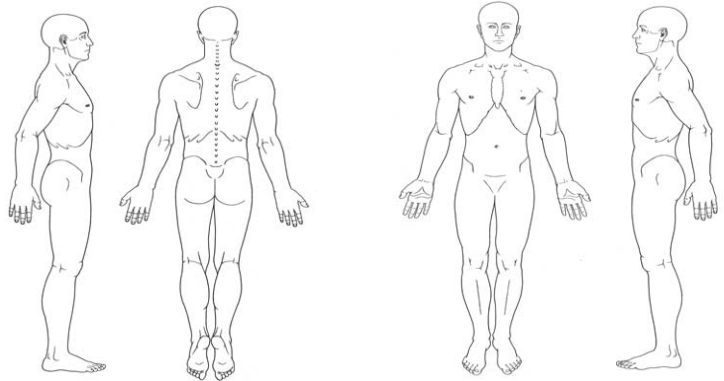
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**3<sup>rd</sup> Condition/Symptom:** \_\_\_\_\_

**4<sup>th</sup> Condition/Symptom:** \_\_\_\_\_

<b>Staff Only:</b>	<b>eRX</b>	<b>eRX Update</b>	<b>Vitals</b>	<b>Transfer Vitals (new case)</b>	<b>Need Meds Info</b>
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**1<sup>st</sup> Condition/Symptom**

Whom have you seen for your symptoms: **NO one** Chiropractor MD Physical Therapist Specialist

What tests have you had for your symptoms: **X-RAYS CT SCAN MRI OTHER:** \_\_\_\_\_

Do you consider your problem to be severe? **Yes Yes, at times No**

What concerns you most about your condition? \_\_\_\_\_

What does it prevent you from doing? \_\_\_\_\_

What alleviates your problem or gives you relief? \_\_\_\_\_

Have you had similar problems in the past? **YES NO** Who did you see and when? \_\_\_\_\_

**2<sup>nd</sup> Condition/Symptom**

Whom have you seen for your symptoms: **NO one** Chiropractor MD Physical Therapist Specialist

What tests have you had for your symptoms: **X-RAYS CT SCAN MRI OTHER:** \_\_\_\_\_

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What alleviates your problem or gives you relief? \_\_\_\_\_

Have you had similar problems in the past? **YES NO** Who did you see and when? \_\_\_\_\_

List your height \_\_\_ ft \_\_\_ in weight \_\_\_\_\_ smoker: **yes no former** BP: \_\_\_\_/\_\_\_\_

Are you allergic to any medications: \_\_\_\_\_

List all your prescription medications (and dosages per day), over the counter medications, supplements and vitamins:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Indicate any procedures and surgeries you had since your last visit in our office: \_\_\_\_\_

\_\_\_\_\_

In general would you say your overall health right now is: **Excellent Very good Good Fair Poor**

**What is your occupation?**

Professional executive White Collar/Secretarial Tradesperson Laborer  
Homemaker FT Student Retired Other: \_\_\_\_\_

If you are not retired, a homemaker, or a student, what is your current work status? Circle

Full-time Self-employed Unemployed Off work Part-time Other