Today's Date:___________________________________

PATIENT INFORMATION

First Name:________________________ Middle Name :________________________ Last Name:________________________

Date of Birth:______________________________ Employment Status: ☐ Full-Time ☐ Part-Time ☐ Student

Allergies:____ Current Medications:____

Pharmacy Name:____ Pharmacy Ph: ______________________________

CHIEF COMPLAINT

Current Age:___________________

Body Part Primary Complaint:____

Body Part Secondary Complaint:____

HISTORY OF PRESENT ILLNESS

Was your pain caused by an injury: ☐ Yes ☐ No

Time since onset of Symptoms:_____________ ☐ Days ☐ Weeks ☐ Months

Symptoms Associated with Chief Complaint: *(check all that apply)*

☐ Pain ☐ Burning ☐ Difficulty Walking ☐ Headache

☐ Joint Stiffness ☐ Muscle Spasms ☐ Numbness ☐ Bladder or Bowel Incontinence

Other: *(please explain)* ____

____

____

Patient's Name:_______________________________________

What treatments have you tried:____

How long have you tried these treatments:___________________ Have you experienced these symptoms before?: Yes No

What treatments helped:____

Did any treatment make it worse:____

PATIENT SOCIAL HISTORY

Smoking Status: ☐ Yes ☐ No

How many cans/packs of *tobacco (chew/snuff cigarettes)*: ____________ How many years have you used tobacco?:_____________

How many alcoholic drinks do you consume in a week?___________

Do you use non-prescribed or recreational drugs? ☐ Yes ☐ No

Are you hard of hearing or deaf in one or both ears? ☐ Yes ☐ No

Are you legally blind in one or both eyes? ☐ Yes ☐ No

Are you exposed to animals? ☐ Yes ☐ No

DEPRESSION ASSESSMENT

Little interest or pleasure in doing things: ☐ Yes ☐ No

Feeling down, depressed or hopeless? ☐ Yes ☐ No

Trouble falling asleep, staying asleep, or sleeping too much: ☐ Yes ☐ No

Feeling tired or having little energy? ☐ Yes ☐ No

Is there any other information we should know about your illness or how you are feeling today?

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