

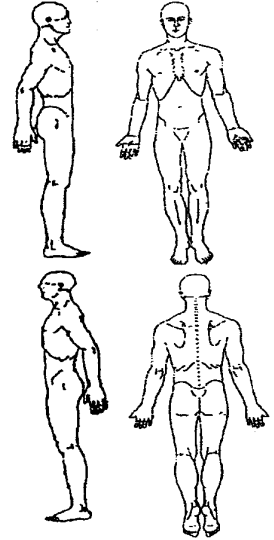
Name: \_\_\_\_\_

Date: \_\_\_\_\_

Describe your health problems/complaints thoroughly use back of page if needed

Please mark below where you have pain

	#1	#2	#3
My Complaint(s) →			
When did it begin?			
What caused it?			
What makes it better?			
What makes it worse?			
Describe the pain or trouble			
Scale your pain 1-10 10 being worst			
How is this affecting your life?			
When does it hurt?			
When was the last time you have had this?			
Who have you seen for this?			



Have you had any surgeries in the last three years? \_\_\_\_\_

Have you had any falls, accidents, or other injuries in the last 6 months? \_\_\_\_\_

**Systems Review—Answer only those that apply now.**

Do you have any?	Yes/No	How Much?	How Often?	Doctor Notes
Headaches	Yes No			
Dizziness	Yes No			
Tiredness	Yes No			
Breathing Trouble	Yes No			
Swallowing Trouble	Yes No			
Indigestion	Yes No			
Heartburn	Yes No			
Gas	Yes No			
Daily Bowel Movements	Yes N			
Loose Stool	Yes No			
Problem Sleeping	Yes No			
Appetite Poor	Yes No			
Nervous	Yes No			
Heart Trouble	Yes No			
Libido	Yes No			
Hot Flashes	Yes No			
Menstrual Problems	Yes No			