



Patient:	DOB:	ID#	Date:
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What problem (s) brought you to see us? _____

When did the problem(s) start? _____

The problem(s) developed: Suddenly Built up over several days Gradually worse over a long time

What kind of pain are you experiencing?

Dull Ache Burning Sharp/Stabbing Pins & Needles Throbbing

Where is the pain?

Foot: Right Left _____

Leg: Right Left _____

Knee: Right Left _____

Hip: Right Left _____

Shoulder: Right Left _____

Hand/Fingers: Right Left _____

Arm: Right Left _____

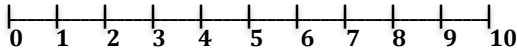
Head: _____

Neck: _____

Back: _____

Other: _____

On a scale of 1 to 10, with 1 being light pain and 10 being very severe, how severe is your pain most of the time and how frequent is your pain?

Intensity (0-10) _____  Frequency (0-100%) _____ %

Numerical Scale

Factors:

Increase Pain: Sit Stand Walk Climb Bend Squat Lay Down Touch
 Up Stairs Down Stairs Movement

Decrease Pain: Sit Stand Walk Climb Bend Squat Lay Down Touch
 Up Stairs Down Stairs Movement

What have you done to manage this pain up to this point?



5471 Kearny Villa Rd Ste 200 San Diego, CA 92024
 Tel. (858) 571-0606 Fax: (858) 571-1933
 499 N. El Camino Real Ste C-200 Encinitas, CA 92024
 Tel. (760) 635-7800 Fax: (760) 635-7801

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Past Medical History

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Compression Fractures | <input type="checkbox"/> Diverticulosis |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Bulging Discs | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> HIV | <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD | <input type="checkbox"/> Other _____ |

Allergies:

MEDICATIONS (Prescription and over the counter)		HOSPITALIZATION AND SURGERY: Surgery and date	
Name and strength	#Doses / day		
FAMILY HISTORY: (mother, father, grandparents, brothers, sisters, children)			
Condition	Who?	Condition	Who?
Heart Disease		Diabetes	
Hypertension		Epilepsy	
Stroke		Bleeding Disorders	
Cancer		Kidney Disease	
Special care or issues that might affect your treatment? <input type="checkbox"/> NO <input type="checkbox"/> YES (describe)			

Procedure	Part of body	Date(s)	Place Performed
X-rays			
C.T./MRI			
Ultrasound			
Nerve Conduction			
Other			



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REVIEW OF SYSTEMS:

GENERAL

- Tire easily
- Recent weight gain
- Recent weight loss
- Night Sweats

ENT

- Blurred vision
- Cataracts
- Hearing loss
- Frequent nosebleeds
- Ringing in the ears

HEM/ENDOCRINE

- Excessive thirst
- Dry mouth
- Anemia
- HIV
- Bruise easily
- Blood clots

RESPIRATORY

- Shortness of breath;
 - At night
 - Laying flat
 - With walking
- Wheezing
- Sputum
- Cough

CARDIOVASCULAR

- Chest pain/tightness: Exertional Non-Exertional
- Edema/Swelling of legs

MENTAL HEALTH

- Anxious
- Depressed
- Difficulty sleeping

GI/GU

- Abdominal pain
- Ulcers
- Heartburn
- Constipation
- Diarrhea
- Trouble swallowing
- Nausea or vomiting
- Urinary Frequency
- Kidney disease
- Incontinence of the bowel or bladder

MUSCULOSKELETAL

- Joints are stiff
- Joints hurt (which joints?)
- Joints are swollen (which joints?)
- Muscles aching
- Muscle weakness
- Gout

SKIN DISORDER

- Skin disorder

NEUROLOGICAL

- Weakness of arms, legs
- Numbness and tingling of arms, legs
- Dizziness
- Headaches
- Seizures
- Fainting
- Tremors

Employment Status: Retired Full Time Part Time Homemaker Student Unemployed

Marital Status: Single Married Widowed

Habits: Tobacco _____ packs/day or Stopped _____
 Alcohol Type/Amount: _____

HT: _____ WT: _____ BP: ____/____ PULSE: _____ RESP: _____ O2SAT: _____ TEMP: _____