Fresh Start
health and wellness

Date:_____

Name:_____Sex:_____Age:_____HT:_____WT_____

Referred By:_____ Primary Care Physician:_____

What symptoms bring you in today?_____
_____
_____

What do you hope to accomplish in the office visit today?_____
_____
_____

USE THE SYMBOLS BELOW AND DRAW ON THE DIAGRAM WHERE YOUR SYMPTOMS ARE.

Ache	Numbness	Pins & Needles	Burning	Stabbing
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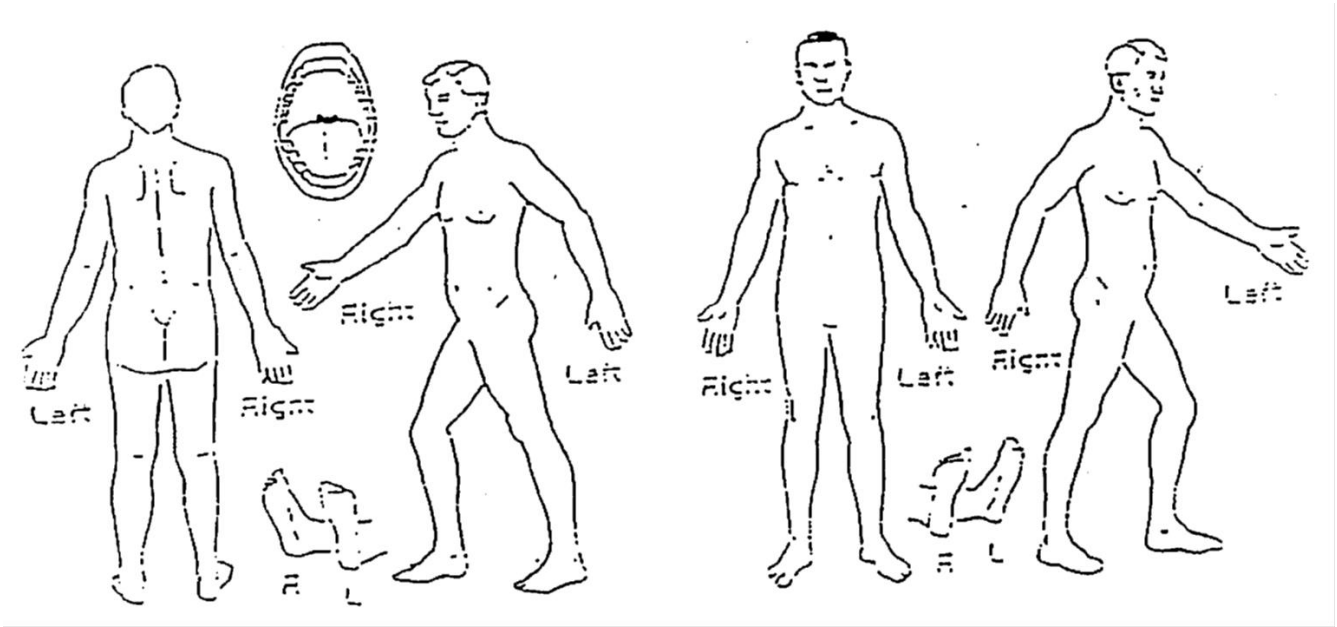

In the last 2 weeks, what has been the level of your:

LEAST pain? (none) 0……..……..……5…….10 (worst pain imaginable)
WORST pain? (none) 0……5…….10 (worst pain imaginable)
Pain TODAY? (none) 0……5…….10 (worst pain imaginable)

List the Physicians, Chiropractors, and/or Osteopaths you have seen regarding these symptoms:

Type of doctor	Doctor's name	Location	Approximate dates

Please indicate the treatments you have had to date for this condition:_____

_____

_____

Past Medical History	
□ High blood pressure	□ Kidney disease □ Kidney Stones
□ Diabetes □ Using insulin	□ HIV or AIDS □ Hepatitis Type __
□ Thyroid problems	□ Tuberculosis □ Tick bite □ MRSA
□ Heart disease □ Heart attack □ Pacemaker	□ Depression □ Other psychiatric disorder
□ Cancer Type? _____	□ Sickle cell anemia □ Anemia
□ Blood clots (DVT/PE)	□ Bleeding problems
□ Stroke □Peripheral neuropathy	□ Rheumatoid arthritis
□ Rash / Skin lesions	□ Osteoporosis □ Osteoarthritis
□ COPD □ Emphysema □Asthma	□ Seizures
□ Concussion	□ Sleep apnea □ Use of CPAP
□ Gout	□ Other: _____
□ Reflux/GERD □ Ulcers	_____

Review of Systems Please select all that you have experienced in the last 6 months			
General Wellbeing	□ Lack of vitality	□ Feeling burned out	□ Lack of energy
Constitutional	□ Unexplained fevers	□ Chills	□ Weight loss
Eyes	□ Blurred vision	□ Double vision	□ Vision loss
Ear/Nose/Throat	□ Earache	□ Hearing loss	□ Throat pain
Cardiovascular	□ Chest pain	□ Fast heart rate	□ Palpitations
Respiratory	□ Persistent cough	□ Sleep apnea	□ CPAP
Gastrointestinal	□ Nausea/vomiting □ Belly pain □ Heartburn/ulcers □ Blood in stool □ Constipation □ Diarrhea		
Genitourinary	□ Painful urination	□ Frequent urination	□ Bladder changes
Musculoskeletal	□ Joint pain or stiffness	□ Muscle aches	□ Loss of balance
Mobility	□ Limited in recreation	□ Problems with exercises	□ Limited in daily activities
Skin	□ Itching	□ Skin Lesion	□ Skin rash
Neurologic	□ Dizziness or Vertigo	□ Fainting	□ Motor disturbance
Psychiatric	□ Diagnosed depression □ Drug/alcohol addiction □ Bipolar □ Under care of psychiatrist		
Emotional	□ Feeling anxious or restless	□ Depressed, lacking drive	□ Irritability or feeling moody
Cognition	□ Unable to concentrate	□ Memory loss	□ Brain fog
Hematalogic	□ Easy bleeding	□ Easy bruising	□ Anemia
Hormonal	□ Night sweats	□ Hot flashes	□ Thyroid problems
Sexual Function	□ Impaired sexual desire	□ Impaired sexual function	□ Impaired sexual satisfaction
Sleep	□ Trouble falling asleep	□ Trouble staying asleep	□ Fatigue

Surgical History (please include approximate dates): □ None

_____

_____

_____

Current Medications (include dosages): □ None

_____

_____

_____

Allergies (include reactions): □ None

_____

_____

_____

Social History:

- Marital status: □ Single □ Married □ Divorced □ Widowed
- Where were you born? _____
- Place where you live now? _____
- Is English your native language? □ Yes □ No
- Highest level of education: _____

- **Lifestyle and Environmental**
  - Tobacco use: □ None □ Previous □ Current _____ Type and _____ Amount/day
  - Alcohol use: □ None □ Previous □ Current _____ Amount/day
  - Illegal drug use □ None □ Previous □ Current If yes, what drug(s)? _____
  - Physical activity: How many days a week do you get moderate exercise? (e.g. brisk walk) _____ Duration: (e.g. minutes) _____
- **Occupational History**
  - Occupation?_____. Where do you work?_____
  - How long have you been at your current job? _____
  - How physically demanding is your job? □ Very heavy (frequently lifting >100 lb) □ Heavy (frequently lifting>60 lbs) □Moderate (frequently lifting >30 lbs) □Light (frequently lifting <30 lbs) □Sedentary (essentially no lifting)
  - Please rate how emotionally stressful your job is: _____ (0=not at all, 10=severe)
  - Are you currently working? □Yes □No
  - How satisfied are you with your job? □ Very satisfied □ Satisfied □ Dissatisfied □ "Worst job I've ever had"