Name: _____ **Date:** ____/ ____ / _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Home/Cell Phone Number: _____ **Work Phone Number:** _____
Age: _____ **Date of Birth:** _____ **Social Security Number:** _____
Gender: Male ☐ **Female** ☐ **Email Address:** _____
Marital Status: (please circle one) M S W D Spouse Name: _____
Occupation: _____
Primary Insurance: _____ **Policy/ID Number:** _____
Policy Holders Name: _____ **Policy Holders Date of Birth:** _____
Secondary Insurance: _____ **Secondary Policy/ID Number:** _____

How did you hear about our office: ☐ **Referral** ☐ **Doctor** ☐ **Website** ☐ **Social Media** ☐ **Other**
If Other, please describe: _____

History of the Present Illness-Primary

#1 History of the Present Illness-What hurts the most; Why are you here?

L Location of present complaint: _____

M Was there a particular event that caused the pain or problem? ☐ Yes ☐ No

- If Yes, Describe:_____

N Are you a new or returning patient? ☐ New ☐ Returning

O When did your present complaint begin? Date: ____/____/____

P What aggravates your condition/ pain? _____

Q Which of these are you feeling:

☐ Numbness ☐ Pins & Needles ☐ Burning ☐ Aching ☐ Stabbing ☐ Dull Ache

R Does the pain/sensation spread or radiate to other areas? ☐ Yes ☐ No

- If Yes, Describe:_____

S Please rate your condition/pain on a scale of 0 to 10 0= no pain 10= most severe pain

- What is the severity of your pain RIGHT NOW? 0 1 2 3 4 5 6 7 8 9 10
- What is the severity of your pain AT ITS BEST? 0 1 2 3 4 5 6 7 8 9 10
- What is the severity of your pain AT ITS WORST? 0 1 2 3 4 5 6 7 8 9 10

T Is the condition/pain worst during certain times of day? ☐ Yes ☐ No, If so Time: _____

Since the condition/pain began, has it gotten: ☐ Better ☐ Worse ☐ Stayed the same

Reviewed By: _____

Review of Systems: Musculoskeletal and Nervous

In addition to the above condition/pain do you have any of the following symptoms?

☐ None ☐ Limited Movement ☐ Difficulty Walking ☐ Dizziness ☐ Headaches
☐ Lack of Coordination ☐ Popping Noises ☐ Stiffness ☐ Visual Disturbance ☐ Weakness

Name of Primary Care Physician: _____

Have you been treated for any healthcare conditions by a physician in the last year? ☐ Yes ☐ No

- If Yes, Describe:_____

For Female Patients Only:

This is to certify to the best of my knowledge I AM NOT PREGNANT and that Dr. Danielle Vann has my consent to take and/or order any necessary x-rays to aid in my care.

Last Menstrual Cycle: ___/___/___ Signature: _____ Date: ___/____/___

Complete this section only if you have more than one complaint.

#2 History of Present Illness-Is there anything else that hurts? Tell us about it below.

L Location of present complaint: _____

M Was there a particular event that caused the pain or problem? ☐ Yes ☐ No

- If Yes, Describe:_____

N Are you a new or returning patient? ☐ New ☐ Returning

O When did your present complaint begin? Date: ____/____/____

P What aggravates your condition/ pain? _____

Q Which of these are you feeling:

☐ Numbness ☐ Pins & Needles ☐ Burning ☐ Aching ☐ Stabbing ☐ Dull Ache

R Does the pain/sensation spread or radiate to other areas? ☐ Yes ☐ No

- If Yes, Describe:_____

S Please rate your condition/pain on a scale of 0 to 10 0= no pain 10= most severe pain

- What is the severity of your pain RIGHT NOW? 0 1 2 3 4 5 6 7 8 9 10
- What is the severity of your pain AT ITS BEST? 0 1 2 3 4 5 6 7 8 9 10
- What is the severity of your pain AT ITS WORST? 0 1 2 3 4 5 6 7 8 9 10

T Is the condition/pain worst during certain times of day? ☐ Yes ☐ No, If so Time: _____

Reviewed By: _____

Since the condition/pain began, has it gotten: ☐ Better ☐ Worse ☐ Stayed the same

Past/Family/Social/Occupational History

Illness(es)

Past/Current Condition	Date of Diagnosis	Past/Current Condition	Date of Diagnosis
☐ **This Section is N/A**			
☐ **Allergies/Sinus**	_____	☐ Heart Disease	_____
☐None ☐ Food ☐Environmental ☐Medication		☐ **High Blood Pressure**	_____
☐ Cancer	_____	☐ HIV	_____
☐ Depression	_____	☐ Kidney Stones	_____
☐ **Diabetes**	_____	☐ Respiratory/Lung	_____
☐ Type I ☐ Type II		☐ Stroke	_____
☐ Fibromyalgia	_____	☐ Thyroid-Condition	_____
☐ Headaches	_____	☐ Ulcers/Stomach	_____

Surgery(s)

Body Region	Approximate Date/Age	Body Region	Approximate Date/Age
☐ **This Section is N/A**	_____		
☐ Abdominal	_____	☐ Foot/Ankle	_____
☐ Back	_____	☐ Hip	_____
☐ Dental	_____	☐ Knee	_____
☐ Fertility/Birth Control	_____	☐ Lung	_____
☐ Gallbladder	_____	☐ Neck	_____
☐ Heart	_____	☐ OB/GYN	_____
☐ Hernia	_____	☐ Shoulder	_____

Medication (s)/ Supplement(s)

☐ **None, This Section is N/A**

	Medication Brand Name	Start Date	Dosage	Condition
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Reviewed By: _____

Occupational History:

- What is your Current Occupation? _____
- Describe your work: ☐ Office/Computer ☐ Heavy Labor ☐ Moderate Labor ☐ Light Labor ☐ Stressful
- Prior job to your current position? _____

Past/Family/Social/Occupational History

Family History:

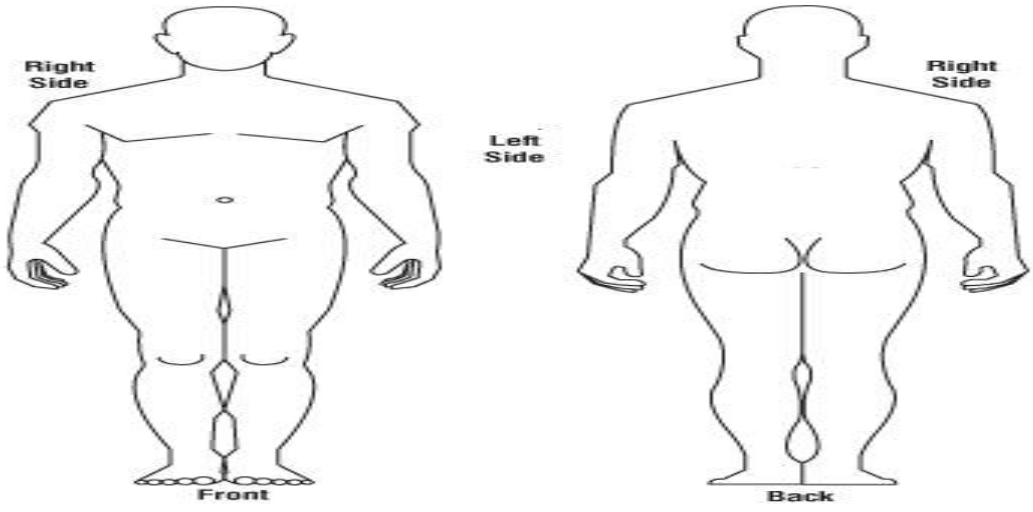
Check the conditions that apply to your Mother and Father below.

Mother	**Father**
☐ Back Pain	☐ Back Pain
☐ Cancer	☐ Cancer
☐ Depression	☐ Depression
☐ Diabetes	☐ Diabetes
□ Type I □ Type II	□ Type I □ Type II
☐ Headaches	☐ Headaches
☐ Heart Disease	☐ Heart Disease
☐ High Blood Pressure	☐ High Blood Pressure
☐ HIV	☐ HIV
☐ Respiratory/Lung	☐ Respiratory/Lung
☐ Stroke	☐ Stroke
☐ Thyroid Condition	☐ Thyroid Condition
☐ Ulcers/Stomach	☐ Ulcers/Stomach

Social History:	Yes	No
• Do you have a balanced diet?	☐	☐
• Do you eat fast food frequently?	☐	☐
• Do you take vitamins?	☐	☐
• Do you exercise routinely?	☐	☐
• Do you sleep well?	☐	☐
• **Do you smoke/use tobacco**?	☐	☐
-How many packs per week? _____		
• Do you drink alcohol?	☐	☐
-How many drinks per week? _____		
• Do you Drink Water ?	☐	☐
-How many cups per day? _____		
• Do you drink caffeine?	☐	☐
-How many drinks per day? _____		

Pain Drawing:

Mark the areas on this body where you feel Pain. Mark ALL affected areas, including radiation. Use symbols in key located on the bottom of the page.



Numbness - - - - - Pins & Needles 0 0 0 0 Burning X X X X Aching * * * * Stabbing/Sharp / / / /

Reviewed By: _____