KAMBOUROUAKIS CHIROPRACTIC

performance and longevity

The following information provided is confidential and is for medical purposes only. It is important you fill it out to the best of your ability. Even if the question seems not to apply to your current condition please fill this form out completely as many things can be connected and will help us better serve you.

Name:____**Today's Date:**______________(mm/dd/yr)

DOB:________(mm/dd/yr) **Current age**:_____**Height**:_____**Weight**:_______**Gender**: □ **male** □ **female**

Address:________________________________**City:**_____________**State:**____**Zip Code:**____________

Home Phone:__________________________Permission to leave a 'medical' message? □ **Yes** □ **No**

Cell Phone:____________________________Permission to leave a 'medical' message? □ **Yes** □ **No**

Email for medical/healthcare correspondence:____

Occupation:____________________________**Employer:**_____________________________________

Emergency Contact Name:________________________________**Phone #:**________________________

Please Describe your current problem/complaint that brought you to our office: List them in order of importance. For example #1 is most important, and #5 is least important. *(if your complaint is of pain please also use the diagram on the following page)*

1.____

2.____

3.____

4.____

5.____

How long have you had the above condition/s?__________________Is it getting worse? □ yes, □ no

Does it effect your (check appropriate box): □ work, □ sleep, □ other:_______________________________

Initial cause of complaint: ____

Major goals for your our first visit: Let us know what you would like to accomplish on your first visit.

1.____

2.____

3.____

4.____

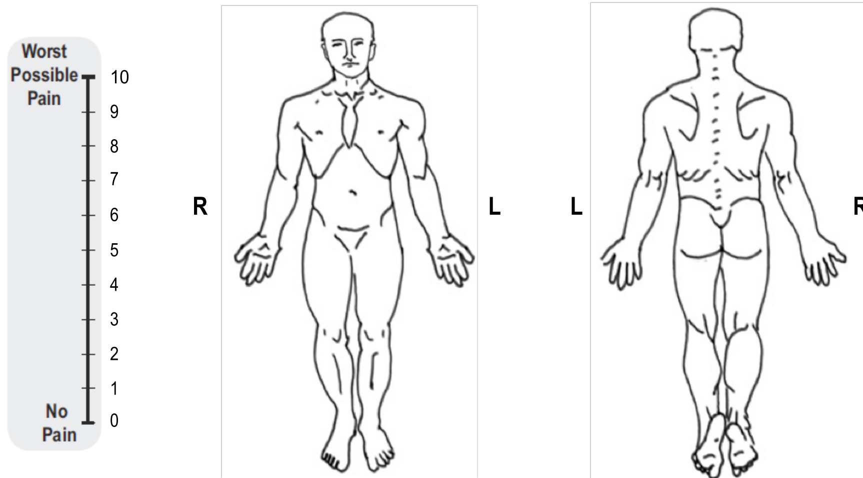
Have you been treated for this condition in the past/present? □ yes, □ no; If YES, by whom?

____

Have you been diagnosed for this condition? □ yes, □ no; Diagnosis:____________________________

Is there anything else the Doctor should know about *you* or your *condition*?__________________________

Please circle a number corresponding with to your pain and use "X"'s and lines to locate your pain and describe any radiation of pain.



PAST HISTORY

Have you…	Yes	No	If yes, explain briefly WITH approximate date/year
... ever been hospitalized?	□	□	____________________
...had any surgeries?	□	□	____________________
...had any mental disorders?	□	□	____________________
...had any broken bones?	□	□	____________________
...had any strains or sprains?	□	□	____________________

Have you ever been bitten by a *tick or spider* that you know of? □ **yes,** □ **no** If yes, did you have a reaction such as a rash, fever, joint pain, etc. □ **yes,** □ **no**

____

Have you ever had mono or Epstein barr virus? □ **yes,** □ **no**

Have you ever been diagnosed with MRSA? □ **yes,** □ **no**

Have you had any other infections? □ **yes,** □ **no**:____________________

Do you have any allergies to foods, medications or environment? ____________________

____

FAMILY HISTORY

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Cancer ____________________
□ High blood pressure ____________________
□ Anemia ____________________
□ Diabetes ____________________
□ High cholesterol ____________________
□ Arteriosclerosis ____________________
□ Emphysema ____________________
□ Multiple sclerosis ____________________

□ Epilepsy ____________________
□ Osteoporosis ____________________
□ Stroke ____________________
□ Bleed easily ____________________
□ Heart disease ____________________
□ Thyroid disease ____________________
□ Dementia/Alzheimer's/Parkinson's ____________
□ OTHER: ____________________

HABITS and LIFESTYLE

Please *circle* any of the following you consume: Alcohol Coffee Tobacco Drugs Soft Drinks OTC meds. Pain Killers Do you exercise regularly? If YES-what do you do? If NO what keeps you from exercise? ______________________

DIET- Do you Follow any particular diet regimen or restrictions?: ____

____

MOST RECENT VISIT TO A DOCTOR: *When was the last time you consulted a doctor, and for what reason?* ____

Date of last complete physical exam: _______________

Date of most recent lab/blood tests: _______________

WOMEN—date of last PAP smear: ___________________results:_______________

Currently pregnant? YES NO UNSURE

Do you still have your monthly period? YES NO UNSURE

Do you have any children? YES NO **How many?**__________ **Healthy?**________________

Name/s of your children:____

Is there anything else the Doctor should know or you would like to elaborate on?:

____

____

____

____

Current <u>prescription medications</u> (e.g., Prozac, lipitor, etc), **<u>non-prescription medications</u>** (e.g., aspirin, Tylenol, ibuprofen) and/or **<u>health supplements</u>** (e.g., vitamins, minerals, herbs): *Please list the medications and/or supplements that you are currently taking. If you need more room please attached a sheet to this form.* ***Please also list any drug allergies.***

NAME *of medication or supplement—drugs, vitamins, herbs, minerals*	**DOSE** *in milligrams or grams (or number of capsules, tablets)*	**FREQUENCY***:* **Times per day/ week/ month**	**DURATION***:* *Been* **taking for how long?**

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REVIEW of SYSTEMS: Simply circle the most appropriate number for each attribute so we can better understand and discuss your current condition. Although this list is extensive it is important to fill out completely and as accurately as possible. If you mark "YES" to a question please provide additional info to the right or on the bottom of the page.

GENERAL HEALTH	Never-Very rare	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Fatigue, lack of energy, lack of stamina	□ 0	□ 1	□ 2	□ 3
Tired even after "good" sleep	□ 0	□ 1	□ 2	□ 3
Lack of desire to get out of bed	□ 0	□ 1	□ 2	□ 3
Undesired weight gain, difficulty losing weight	□ 0	□ 1	□ 2	□ 3
Undesired weight loss	□ 0	□ 1	□ 2	□ 3
Hard time falling asleep	□ 0	□ 1	□ 2	□ 3
Hard time staying asleep	□ 0	□ 1	□ 2	□ 3
Faint/dizzy/nauseous if a meal is skipped	□ 0	□ 1	□ 2	□ 3
Decreased appetite	□ 0	□ 1	□ 2	□ 3
Food or environmental allergies	□ 0	□ 1	□ 2	□ 3
Sensitive to perfumes, chemical smells, exhaust, etc.	□ 0	□ 1	□ 2	□ 3
Cold sores and blisters	□ 0	□ 1	□ 2	□ 3
Morning stiffness/muscle cramps	□ 0	□ 1	□ 2	□ 3
Pain at night/Night sweats	□ 0	□ 1	□ 2	□ 3
Past or present diagnosis of serious conditions such as : cancer, systemic infection, kidneys disease, heart disease or other	□ **NO**	□ **YES —>**		

HAIR, SKIN, and NAILS	Never-Very rare	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Oily or dry skin (please circle	□ 0	□ 1	□ 2	□ 3
Eczema	□ 0	□ 1	□ 2	□ 3
Psoriasis	□ 0	□ 1	□ 2	□ 3
White spots on finger nails	□ 0	□ 1	□ 2	□ 3
Small bumps on the back of the arms	□ 0	□ 1	□ 2	□ 3
Skin rash or fungal infection	□ 0	□ 1	□ 2	□ 3
Increased body or facial hair	□ 0	□ 1	□ 2	□ 3

Decrease in body or facial hair	☐ 0	☐ 1	☐ 2	☐ 3
Acne	☐ 0	☐ 1	☐ 2	☐ 3
Discoloration or depigmentation of skin	☐ 0	☐ 1	☐ 2	☐ 3
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

HEAD and MIND	Never-Very rare	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Lack of desire to get out of bed	☐ 0	☐ 1	☐ 2	☐ 3
Headaches or Migraines (please circle)	☐ 0	☐ 1	☐ 2	☐ 3
Loss of consciousness or feeling faint, dizzy	☐ 0	☐ 1	☐ 2	☐ 3
Hard time remembering (long or short term)	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty speaking or "finding" words	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty concentrating	☐ 0	☐ 1	☐ 2	☐ 3
Dyslexia or word confusion	☐ 0	☐ 1	☐ 2	☐ 3
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		
Feelings of sadness or depression	☐ 0	☐ 1	☐ 2	☐ 3
Anxiety and stress	☐ 0	☐ 1	☐ 2	☐ 3
Inability to cope with stressful situations	☐ 0	☐ 1	☐ 2	☐ 3
Lack of interest or concern	☐ 0	☐ 1	☐ 2	☐ 3
Mental sluggishness	☐ 0	☐ 1	☐ 2	☐ 3
Use of alcohol, drugs, vitamins/minerals/ herbals to deal with stress	☐ 0	☐ 1	☐ 2	☐ 3
Recent or current thoughts of suicide	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty speaking or "finding" words	☐ 0	☐ 1	☐ 2	☐ 3
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		
Diagnoses of any mental disorder-depression, bipolar, schizophrenia or other	☐ **NO**	☐ **YES —>**		

CARDIOVASCULAR and PULMONARY	Never-Very rare	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Pain in the chest, left arm, and/or left side of neck	☐ 0	☐ 1	☐ 2	☐ 3
Shortness of breath upon relaxation or exertion	☐ 0	☐ 1	☐ 2	☐ 3
Swelling in upper or lower extremities	☐ 0	☐ 1	☐ 2	☐ 3
Irregular heart beat	☐ 0	☐ 1	☐ 2	☐ 3

Pounding heart beat heard when resting your head on a pillow	☐ 0	☐ 1	☐ 2	☐ 3
Rapid heart beat	☐ 0	☐ 1	☐ 2	☐ 3
Irregular breathing or discomfort	☐ 0	☐ 1	☐ 2	☐ 3
“Blushed” or red faced	☐ 0	☐ 1	☐ 2	☐ 3
Tightness of the chest	☐ 0	☐ 1	☐ 2	☐ 3
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

EYES, EARS, NOSE, THROAT	Never-Very rare	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Watery, red, or itchy eyes	☐ 0	☐ 1	☐ 2	☐ 3
Dark circles under eyes	☐ 0	☐ 1	☐ 2	☐ 3
Loss of vision/Blurry vision	☐ 0	☐ 1	☐ 2	☐ 3
Hard to see at night	☐ 0	☐ 1	☐ 2	☐ 3
Pain in, near, or behind the eye	☐ 0	☐ 1	☐ 2	☐ 3
Earache or pain in the ears	☐ 0	☐ 1	☐ 2	☐ 3
Tinnitus/ Ringing in the ears	☐ 0	☐ 1	☐ 2	☐ 3
Reoccurring ear infections	☐ 0	☐ 1	☐ 2	☐ 3
Decrease or loss of hearing	☐ 0	☐ 1	☐ 2	☐ 3
Enlarged lymph nodes under the chin/jaw/ on the neck	☐ 0	☐ 1	☐ 2	☐ 3
Bleeding/ sore gums	☐ 0	☐ 1	☐ 2	☐ 3
Tongue has a white coating	☐ 0	☐ 1	☐ 2	☐ 3
Dry mouth, eyes, and/or nose	☐ 0	☐ 1	☐ 2	☐ 3
Halitosis/ bad breath	☐ 0	☐ 1	☐ 2	☐ 3
Sore throat	☐ 0	☐ 1	☐ 2	☐ 3
Excessive mucous formation	☐ 0	☐ 1	☐ 2	☐ 3
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

GENITO-URINARY	Never-Very rare	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Pain in the mid to lower back	☐ 0	☐ 1	☐ 2	☐ 3
Kidney stones	☐ 0	☐ 1	☐ 2	☐ 3

Cloudy, bloody, or dark urine	☐ 0	☐ 1	☐ 2	☐ 3
Urinary tract infections	☐ 0	☐ 1	☐ 2	☐ 3
Frequent urination	☐ 0	☐ 1	☐ 2	☐ 3
Painful urination	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty controlling urination, incontinence	☐ 0	☐ 1	☐ 2	☐ 3
Low sex drive/ libido	☐ 0	☐ 1	☐ 2	☐ 3
HIV test	☐ NOT	☐ YES —>	☐ Positive	☐ Negative
Sexually transmitted disease	☐ **NO**	☐ **YES —>**		
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

GASTROINTESTINAL	Never-Very rare	Occasional-Mild	Intermittent -Moderate	Frequent-Severe
Constipation / Diarrhea (please circle)	☐ 0	☐ 1	☐ 2	☐ 3
Gas or bloating	☐ 0	☐ 1	☐ 2	☐ 3
Nausea / Vomiting (please circle)	☐ 0	☐ 1	☐ 2	☐ 3
Pains in the stomach or lower abdomen	☐ 0	☐ 1	☐ 2	☐ 3
Heartburn or “GERD”	☐ 0	☐ 1	☐ 2	☐ 3
Sense of fullness after meals	☐ 0	☐ 1	☐ 2	☐ 3
Tired after meals or feel better if you skip meals	☐ 0	☐ 1	☐ 2	☐ 3
Undigested food in stool	☐ 0	☐ 1	☐ 2	☐ 3
Food allergies	☐ 0	☐ 1	☐ 2	☐ 3
Mucous build up/ sinus congestion after meals	☐ 0	☐ 1	☐ 2	☐ 3
Greasy or fatty foods upset your stomach	☐ 0	☐ 1	☐ 2	☐ 3
Anal itching	☐ 0	☐ 1	☐ 2	☐ 3
Coated white tongue	☐ 0	☐ 1	☐ 2	☐ 3
Fungal or yeast infections	☐ 0	☐ 1	☐ 2	☐ 3
Symptoms get worse after eating sugar	☐ 0	☐ 1	☐ 2	☐ 3
Dark circles under the eyes	☐ 0	☐ 1	☐ 2	☐ 3
Hemorrhoids	☐ 0	☐ 1	☐ 2	☐ 3
Blood or mucous in the stool (please circle)	☐ 0	☐ 1	☐ 2	☐ 3
Crohn’s disease or Celiac disease (please circle)	☐ **NO**	☐ **YES —>**		
History of alcohol abuse	☐ **NO**	☐ **YES —>**		

History of hepatitis	☐ **NO**	☐ **YES —>**		
Long term use of prescription/recreational drugs	☐ **NO**	☐ **YES —>**		
Loss of bowel control, incontinence	☐ **NO**	☐ **YES —>**		
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

MALE ONLY	Never-Very rare	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Difficulty or painful erections	☐ 0	☐ 1	☐ 2	☐ 3
Cloudy, bloody, or dark urine	☐ 0	☐ 1	☐ 2	☐ 3
Painful or difficulty with ejaculation	☐ 0	☐ 1	☐ 2	☐ 3
Waking to urinate at night	☐ 0	☐ 1	☐ 2	☐ 3
Decreased sexual function	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty controlling urination, incontinence	☐ 0	☐ 1	☐ 2	☐ 3
Family history of prostate cancer	☐ **NO**	☐ **YES —>**		
Painful/tender testis	☐ **NO**	☐ **YES —>**		
Undescended testis, testis in abdomen or pelvis	☐ **NO**	☐ **YES —>**		
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

FEMALE ONLY	Never-Very rare	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Irregular or painful menses	☐ 0	☐ 1	☐ 2	☐ 3
Pain between cycles	☐ 0	☐ 1	☐ 2	☐ 3
Heavy clotting	☐ 0	☐ 1	☐ 2	☐ 3
Painful, swollen, fibrocystic breasts	☐ 0	☐ 1	☐ 2	☐ 3
Excessive bleeding	☐ 0	☐ 1	☐ 2	☐ 3
Painful intercouse	☐ 0	☐ 1	☐ 2	☐ 3
Hot flashes or fluctuations in temperature	☐ 0	☐ 1	☐ 2	☐ 3
Yeast infections/ vaginal itching	☐ 0	☐ 1	☐ 2	☐ 3
Mood fluctuations that follow your cycle	☐ 0	☐ 1	☐ 2	☐ 3
The use of birth control pill	☐ 0	☐ 1	☐ 2	☐ 3
Menopausal symptoms or concerns	☐ **NO**	☐ **YES —>**		
Infertility	☐ **NO**	☐ **YES —>**		

Poly cystic ovarian syndrome (PCOS)	◻ **NO**	◻ **YES —>**		
Family history of breast, uterine, or ovarian cancer?	◻ **NO**	◻ **YES —>**		
Annual female exam: breast, pap smear, etc.?	◻ **NO**	◻ **YES**		
Other problems or concerns in this area	◻ **NO**	◻ **YES —>**		

Patient Name (print) ____

Patient/Guardian Signature____

Date ______________________

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