



**First Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_ **Last Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

**E-mail** \_\_\_\_\_

**Sex** M \_\_\_ F \_\_\_ **Age** \_\_\_\_\_ **Birth date** \_\_\_\_\_

**Single** \_\_\_ **Married** \_\_\_ **Widowed** \_\_\_

**Patient Employed by** \_\_\_\_\_

**Occupation** \_\_\_\_\_

**Business Address** \_\_\_\_\_

**Business Phone** \_\_\_\_\_

**Business Email** \_\_\_\_\_

**Whom may we thank for referring you?**

\_\_\_\_\_

**Notify in case of emergency** \_\_\_\_\_

**Home Phone** \_\_\_\_\_

**Cell Phone** \_\_\_\_\_ **Business Phone** \_\_\_\_\_

**Email** \_\_\_\_\_

**Please list any Medical Doctor, Chiropractic Physicians or Acupuncturists seen for this condition; date, diagnosis, treatment and the effects their treatment had on your condition.**



7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

**Changes in Current Medications in the Past 6 Months**

**Directions: Please list the medications you are currently taking. List the medical condition for which you are taking the medication. List the dosage of the medication. List the frequency of medication. If prescribed as needed, estimate the amount taken over time. Place a NA in the blank if you do not take any medications.**

**Changes in Medication Taken For Dosage Frequency**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

**On a scale of 0-10 (1 equals no pain and 10 equals severe pain), place a number between 0 and 10 in each space for Frequency and Intensity. Only use one number not a range. (Example 5 not 4-6)**

**Use a number that averages the last month. If you are on medications, use how you feel over the past month on these medications. Do not guess how you might feel without your medications.**

		Frequency	Intensity
Head	Headache		

	<b>Whole head</b>		
	<b>Back of Head</b>		
	<b>Forehead</b>		
	<b>Right Temple</b>		
	<b>Left Temple</b>		
	<b>Migraine</b>		
	<b>"Heavy" Head</b>		
	<b>Memory Loss</b>		
	<b>Hearing Loss</b>		
	<b>Pain in Ears</b>		
	<b>Smell Loss</b>		
	<b>Taste Loss</b>		
	<b>Balance Loss</b>		
	<b>Eye Pain</b>		
	<b>Light Sensitivity</b>		
	<b>Blurred Vision</b>		
	<b>Fainting</b>		
	<b>Lightheaded</b>		
	<b>Dizziness</b>		
	<b>Ear Ringing</b>		
	<b>Ears Buzzing</b>		
	<b>Right Facial Pain</b>		
	<b>Left Facial Pain</b>		
	<b>Teeth Pain</b>		
<b>Neck</b>	<b>Neck Pain</b>		
	<b>Movement Pain</b>		
	<b>Feels Out</b>		
	<b>Neck Stiff</b>		
	<b>Muscle Spasm</b>		
	<b>Neck Grinds</b>		
	<b>Difficulty Swallowing</b>		
	<b>Popping</b>		

	<b>Nerve Feels Pinched</b>		
<b>Shoulders / Arms</b>	<b>Right Shoulder Pain</b>		
	<b>Left Shoulder Pain</b>		
	<b>Across Shoulder Pain</b>		
	<b>Cannot Lift Arm</b>		
	<b>Above shoulder Level</b>		
	<b>Can't Lift Arm Over Head</b>		
	<b>Nerve Pain Right Shoulder</b>		
	<b>Nerve Pain Left Shoulder</b>		
	<b>Shoulder Spasm</b>		
	<b>Tense in Shoulder</b>		
	<b>Pain Right Forearm</b>		
	<b>Pain Left Forearm</b>		
	<b>Pains Right Hand Fingers</b>		
	<b>Pains Left Hand Fingers</b>		
	<b>Hands Cold</b>		
	<b>Swelling Right Hand</b>		
	<b>Swelling Left Hand</b>		
	<b>Pain Right Wrist</b>		
	<b>Pain Left Wrist</b>		
	<b>Pain Right Hand</b>		
	<b>Pain Left Hand</b>		
	<b>Pain Right Arm</b>		
	<b>Pain Left Arm</b>		
	<b>Arthritis Right Hand Fingers</b>		
	<b>Arthritis Left Hand Fingers</b>		
	<b>Weak Grip Right Hand</b>		
	<b>Weak Grip Left Hand</b>		
<b>Mid Back / Chest</b>	<b>Mid Back Pain</b>		
	<b>Pain Between Shoulder Blades</b>		

	<b>Spasms Mid Back</b>		
	<b>Chest Pain</b>		
	<b>Shortness of Breath</b>		
	<b>Pain in Right Ribs</b>		
	<b>Pain in Left Ribs</b>		
<b>Low Back</b>	<b>Low Back Pain</b>		
	<b>When working</b>		
	<b>When Lifting</b>		
	<b>When Stooping</b>		
	<b>When Standing</b>		
	<b>When Sitting</b>		
	<b>When Bending</b>		
	<b>When Coughing</b>		
	<b>When Lying down</b>		
	<b>Low Back Out</b>		
	<b>Muscle Spasms</b>		
	<b>Arthritis</b>		
<b>Abdomen</b>	<b>Nausea</b>		
	<b>Gas</b>		
	<b>Constipation</b>		
	<b>Diarrhea</b>		
	<b>Menstrual Pain</b>		
	<b>Cramping</b>		
	<b>Irregularity</b>		
	<b>Abdominal Pain</b>		
<b>Hips / Legs / Feet</b>	<b>Pain Right Buttocks</b>		
	<b>Pain Left Buttocks</b>		
	<b>Pain Right Hip</b>		
	<b>Pain Left Hip</b>		
	<b>Pain Right Thigh</b>		
	<b>Pain Left Thigh</b>		

	<b>Pain Right Leg</b>		
	<b>Pain Left Leg</b>		
	<b>Pain Right Ankle</b>		
	<b>Pain Left Ankle</b>		
	<b>Pain Right Foot</b>		
	<b>Pain Left Foot</b>		
	<b>Cramps Right Leg</b>		
	<b>Cramps Left Leg</b>		
	<b>Numb Right Leg</b>		
	<b>Numb Left Leg</b>		
	<b>Numb Right Foot</b>		
	<b>Numb Left Foot</b>		
	<b>Numb toes ( right foot)</b>		
	<b>Numb toes (left foot)</b>		
	<b>Cold Right Foot</b>		
	<b>Cold Left Foot</b>		
	<b>Burning Right Foot</b>		
	<b>Burning Left Foot</b>		
	<b>Cramps Right Foot</b>		
	<b>Cramps Left Foot</b>		
	<b>Swollen Right Ankle</b>		
	<b>Swollen Left Ankle</b>		
	<b>Swollen Right Foot</b>		
	<b>Swollen Left Foot</b>		
	<b>Pain in Toes (right foot)</b>		
	<b>Pain in Toes (left foot)</b>		
<b>General</b>			
	<b>Fatigued</b>		
	<b>Teeth Grinding</b>		
	<b>Run Down</b>		
	<b>Insomnia</b>		
	<b>Restless Legs</b>		

	<b>Skin Itches</b>		
	<b>Wake up Exhausted</b>		
	<b>Irritable bowel Syndrome</b>		
	<b>Asthma or Hay fever</b>		
	<b>Forgetful</b>		
	<b>Foggy Minded</b>		
	<b>Difficulty Breathing</b>		
	<b>Skin Sensitivity</b>		
	<b>Over all Body Pain</b>		
	<b>Nausea</b>		
	<b>Chronic Fatigue</b>		
<b>Physiological</b>			
	<b>Suicidal Feelings</b>		
	<b>Suicidal Plans</b>		
	<b>Suicidal Attempts (1 meaning seldom)</b>		
	<b>Depressed</b>		
	<b>Panic Attacks</b>		
	<b>Nervousness</b>		
	<b>Anxiety</b>		
	<b>Irritable</b>		
	<b>Loss of periods of time</b>		

**Activities that effect your Fibromyalgia**

<b>Activity</b>	<b>Better</b>	<b>Worse</b>
<b>Walking</b>		
<b>Swimming</b>		
<b>Sleeping</b>		
<b>Working</b>		
<b>Lifting</b>		

<b>Bending</b>		
<b>Stooping</b>		
<b>Pulling</b>		
<b>Exercise</b>		
<b>Intercourse</b>		

How many hours do you sleep each day? \_\_\_\_\_

How many hours do you spend in bed each day? \_\_\_\_\_

**Global Health Scale**

Rate your general well-being

Poor 0 \_\_\_\_\_ 5 \_\_\_\_\_ 10 Good

**Surgeries**

**Directions:** Please answer the questions to the best of your knowledge and be as specific as possible in giving date information. If you have not had any surgeries, please write NA in the blanks below and do not answer questions A, B, and C.

Please list any surgery performed with the intent to help your Fibromyalgia and the date of the surgery.

1. \_\_\_\_\_

**Directions:** Please circle the answer that best applies. If you answered no to question A below, then skip question B and C below.

**A. Did the surgery affect your Fibromyalgia symptoms? YES NO**

**B. Were your Fibromyalgia symptoms increased? YES NO**

**C. Were your Fibromyalgia symptoms decreased? YES NO**

Please list any surgery performed with the intent to help your Fibromyalgia and the date of the surgery.

2. \_\_\_\_\_

**Directions:** Please circle the answer that best applies. If you answered no to question A below, then skip question B and C below.

**A. Did the surgery affect your Fibromyalgia symptoms? YES NO**

**B. Were your Fibromyalgia symptoms increased? YES NO**

**C. Were your Fibromyalgia symptoms decreased? YES NO**

**Please list any surgery performed with the intent to help your Fibromyalgia and the date of the surgery.**

**3. \_\_\_\_\_**

**Directions: Please circle the answer that best applies. If you answered no to question A below, then skip question B and C below.**

**A. Did the surgery affect your Fibromyalgia symptoms? YES NO**

**B. Were your Fibromyalgia symptoms increased? YES NO**

**C. Were your Fibromyalgia symptoms decreased? YES NO**

**Please list any surgery performed with the intent to help your Fibromyalgia and the date of the surgery.**

**4. \_\_\_\_\_**

**A. Did the surgery affect your Fibromyalgia symptoms? YES NO**

**B. Were your Fibromyalgia symptoms increased? YES NO**

**C. Were your Fibromyalgia symptoms decreased? YES NO**

**Please list any surgery performed with the intent to help your Fibromyalgia and the date of the surgery.**

**5. \_\_\_\_\_**

**Directions: Please circle the answer that best applies. If you answered no to question A below, then skip question B and C below.**

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**A. Did the surgery affect your Fibromyalgia symptoms? YES NO**

**B. Were your Fibromyalgia symptoms increased? YES NO**

**C. Were your Fibromyalgia symptoms decreased? YES NO**

**Other illnesses that have required surgery**

**Directions: Please list any other physical illnesses diagnosed which required surgery.. Answer the questions to the best of your knowledge and be as specific as possible in giving**

**date information. Please write NA in the blanks below.**

**Please list the physical illness, the related surgery, and the date of the surgery**

**1. \_\_\_\_\_**

**A. Did the surgery affect your Fibromyalgia symptoms? YES NO**

**B. Were your Fibromyalgia symptoms increased? YES NO**

**C. Were your Fibromyalgia symptoms decreased? YES NO**

**Please list the physical illness, the related surgery, and the date of the surgery**

**2. \_\_\_\_\_**

**A. Did the surgery affect your Fibromyalgia symptoms? YES NO**

**B. Were your Fibromyalgia symptoms increased? YES NO**

**C. Were your Fibromyalgia symptoms decreased? YES NO**

**Please list the physical illness, the related surgery, and the date of the surgery**

**3. \_\_\_\_\_**

**A. Did the surgery affect your Fibromyalgia symptoms? YES NO**

**B. Were your Fibromyalgia symptoms increased? YES NO**

**C. Were your Fibromyalgia symptoms decreased? YES NO**

**Please list the physical illness, the related surgery, and the date of the surgery**

**4. \_\_\_\_\_**

**A. Did the surgery affect your Fibromyalgia symptoms? YES NO**

**B. Were your Fibromyalgia symptoms increased? YES NO**

**C. Were your Fibromyalgia symptoms decreased? YES NO**

**Please list the physical illness, the related surgery, and the date of the surgery**

**5. \_\_\_\_\_**

**A. Did the surgery affect your Fibromyalgia symptoms? YES NO**

**B. Were your Fibromyalgia symptoms increased? YES NO**

**C. Were your Fibromyalgia symptoms decreased? YES NO**

**Directions: Please list any psychological illnesses diagnosed. Answer the questions to the**

**best of your knowledge and be as specific as possible in giving date information. If you do not have a diagnosed psychiatric illness, please write NA in the blanks below**

**Psychological Diagnosis      Date of Psychological Diagnosis**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

**Name** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_