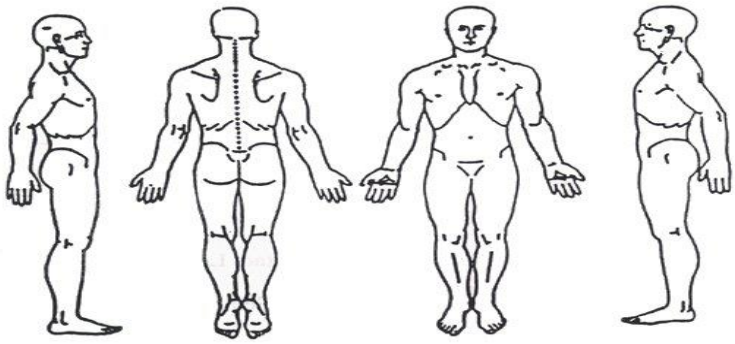
First Name: _____Last Name: _____Date: _____
Home Phone: _____ Work Phone _____
Cell Phone:_____ Street Address and Number:_____
City_____State_____Zip_____
Social Security # _____ Email Address:_____ Age_____
Date of Birth _____ Sex: Male Female Marital Status (Circle One): Married Single
Widowed Divorced Occupation: _____Employer: _____
Work Status: □ full time □ part time Student: □ full time □ part time
Driver's License #_____State _____ How were you referred to our office? _____
In case of emergency, please contact (include phone #) _____
Are today's problems related to: Auto Injury____ Workman's Compensation____ Neither_____

1. Please describe your condition(s) beginning with the most severe and rate the pain– 10 being worse.
1._____(__ /10) 2._____(__ /10)
3._____(__/10) 4._____(__/10)
5._____(__/10) 6._____(__/10)

2. How often do you experience pain?____ Constantly (75-100%) ___Frequently (50-75%) ___Occasionally (25-50%) ___Intermittently (1-25%)

3. How would you describe the type of pain? (Please indicate on the diagram below where you have symptoms)

A= Ache
D = Dull
B = Burn
S = Sharp
SH – Shooting
O = Other



4. How are your symptoms changing with time? □ Getting Worse □ Staying the Same □ Getting Better 6. How much has the problem interfered with your work? □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely
5. How much has the problem interfered with your social activities? □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely
6. Who else have you seen for your problem? □ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician □ Orthopedist □ Other:_____ Who:_____
Treatment?_____ 7. How long have you had this problem? _____
8. How do you think your problem began?
_____
9. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No 10. a. What aggravates your problem?_____ b. What makes it better?_____

11. What concerns you the most about your problem; what does it prevent you from doing?_____

12. How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □Poor

13. What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None

14. Family History: Place an (X) if any family member has suffered from: □ Heart Disease □Diabetes □Cancer □ Mental Illness □ Stroke/Seizures □ High Blood Pressure □ Kidney Disease □ Allergy □ Spinal Disorder □ Arthritis □ Migraine □ Other_____

15. For each of the conditions listed below, circle which applies and write brief description below it:

Review of Systems	Questions	Patient Response
Constitunal	Changes in weight? Fever? Chills? Loss of Appetite? Loss if Energy? Weakness?	
Cardiovascular	Chest Pain? Palpations? Loss of Consciousness? Swollen ankles? Trouble breathing when sitting? On exertion?	
Respiratory	Trouble breathing? Cough? Wheezing? Coughing up blood?	
Allergies	Itching? Hay fever? HIV exposure?	
Integumentary	Rashes? Cuts that won't heal? Unexplained bruises?	
Psychiatric	Depression? Anxiety? Memory Loss? Hallucinations? Suicidal Thoughts?	
Eyes	Discharge? Irritation? Changes in Vision (blurred, double, loss)? Eye Pain? Photophobia?	
Gastrointestinal	Nausea? Vomiting? Diarrhea? Constipation? Change in bowel habits (bloody, tarry)? Jaundice?	
Genitourinary	Discharge? Incontinence? Difficult urination? Increased frequency? Bloody? Pelvic Pain? STD?	
Musculoskeletal	Arthritis? Muscle pain? Fibromyalgia? Weakness?	
Neurologic	Paresthesia? Seizure? Tremors? Vertigo? Numbness? Imbalance? Incardination? Tinnitus? Transient Paralysis?	
Ear/Nose/Throat	Earache? Discharge? Tinnitus? Loss of Hearing? Nasal Congestion? Sore Throat? Dysphasia? Dysphagia?	
Endocrine	Cold intolerance? Heat Intolerance? Increased thirst? Eating? Urination?	
Hematological/lymph	Abnormal bruising? Abnormal bleeding? Tender lymph nodes?	

For Females Only □ □ Birth Control Pills □ □ Hormonal Replacement □ □ Pregnancy

18. List all prescription medications you are currently taking:_____
19. List all surgical procedures you have had:_____
20. Have you ever been hospitalized? □ No □ Yes if yes, why _____
21. Have you had significant past trauma? □ No □ Yes
22. Anything else pertinent to your visit today?_____

BY SIGNING YOUR NAME BELOW, YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO DR. KASSAB'S OFFICE FOR EVALUATION AND TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.

_____

Signature of patient, or of Guardian authorizing care Date