GENERAL HEALTH REVIEW

NAME: ____ DATE:________________

AGE: _______ SEX:______ HANDED: R L RACE:______ HEIGHT:______ WEIGHT:_____LBS

REFERRING PHYSICIAN: ______________________________ Date of last visit______________

PRIMARY CARE DOCTOR: ____

DATE OF ONSET/ INJURY:__________CHIEF COMPLAINT:______________________________

____

Since the onset of the symptoms that brought you here today have you experienced?

NIGHT PAIN……………….…..	YES/NO	NUMBNESS……………………	YES/NO
UNEXPLAINED WEIGHT CHANGE…...	YES/NO	PINS & NEEDLES………………	YES/NO
BOWEL DYSFUNCTION………………..	YES/NO	WEAKNESS…………………...	YES/NO
SEXUAL DYSFUNCTION…………..…	YES/NO	LOSS OF ENERGY…………….	YES/NO
SHORTNESS OF BREATH…………..…	YES/NO	DIZZINESS OR LIGHT-HEADED	YES/NO

In the past 7 days, have you experienced any of the following?

FEVER, CHILLS OR SWEATS…………	YES/NO	PAIN ON URINATING…………..	YES/NO
NAUSEA OR VOMITING………………..	YES/NO	HEADACHES…………………	YES/NO
URINARY FREQUENCY CHANGES………..	YES/NO	INCREASED STRESS …………..	YES/NO
CHANGE OF APPETITE…………………	YES/NO		

Have you ever been diagnosed with the following problems or medical conditions?

HEART DISEASE……………….	YES/NO	HIGH BLOOD PRESSURE……..	YES/NO
CANCER…………………………	YES/NO	BLEEDING DISORDERS………	YES/NO
DIABETES………………………	YES/NO	THYROID DISEASE…………	YES/NO
ANGINA/CHEST PAIN…………	YES/NO	ARTHRITIS……………..	YES/NO
STROKE…………………………	YES/NO	OSTEOPOROSIS……….	YES/NO
RESPIRATORY DISEASE……..	YES/NO	SEIZURES……………………….	YES/NO
INFECTIOUS DISEASE…………	YES/NO	DEPRESSION…………..	YES/NO
ALLERGIES………………………	YES/NO	SUBSTANCE ABUSE…………..	YES/NO
		EMOTIONAL ABUSE…………..	YES/NO

IF YES, PLEASE COMMENT: ____

____

Do you have any other health issues we should know about? Yes/No Please explain: _________

____

Have you had any recent or major surgeries? Yes/No Please explain: ____________________

How many times have you fallen in the past year?____________________________________

OVER

NAME: ______________________________

Do you smoke? Yes/No Packs/day_______________ For how long (yrs.) _________________

Do you drink alcoholic beverages? Yes/No If yes, ________/week or ___________/day

Please list all **medications with dosages:** check(__)see attached list

____

____

What type of work do you do? ____

____

What is your favorite leisure activity? ____

What recreational or fitness activities do you do? ______________________________________

____

What activities have become limited because of your current problem? _____________________

____

What is your current pain level?

0 1 2 3 4 5 6 7 8 9 10

No pain Extreme pain

Please describe your pain and mark its location below on figure: ________________________

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