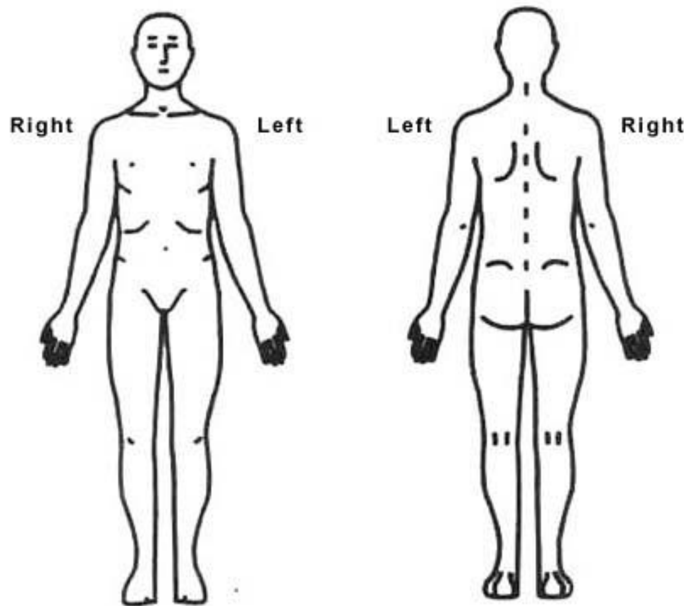
AdvancedWellness
A Comprehensive Wellness Approach

Name:___________________________________ DOB: _________________Today's Date: _________________

Reason for Visit: ____

Have you treated elsewhere for this condition? _______ If so, where? __________________________________

Pain Locator (Please make an X on the body part to indicate areas of pain):



Rate your pain level from 0-10 (0=no pain, 1-3=mild, 4-6=moderate, 7-9=severe, 10=worst pain possible)

Neck Pain:	0	1	2	3	4	5	6	7	8	9	10
Midback Pain:	0	1	2	3	4	5	6	7	8	9	10
Low Back Pain:	0	1	2	3	4	5	6	7	8	9	10
Joint Pain________:	0	1	2	3	4	5	6	7	8	9	10

When did symptoms begin?_____________ What caused your pain? ____________________________________

Other symptoms associated with pain: Numbness Tingling Muscle Spasm Weakness
Headache Dizziness Difficulty Walking Clicking/Grinding
Bowel/bladder leakage Decreased Movement Joint Swelling Joint Stiffness

Is the pain: Dull Aching Sharp / Stabbing Throbbing Burning Pins/Needles Tight / Cramping Soreness Shooting

Does the pain: Radiate down the RIGHT or LEFT arm, down to the SHOULDER / ELBOW / HAND
Radiate down the RIGHT or LEFT leg down to the HIP / THIGH / KNEE / ANKLE / TOES

Is the pain: Constant Intermittent (comes and goes)

Is the pain getting: BETTER WORSE STAYING THE SAME FLUCTUATING

What makes the pain worse: Standing/ Sitting; Walking; Movement Lying down Bending forward
Bending backwards Lifting Bowel Movement Cough/Sneeze Hot weather Cold weather

What makes the pain better: Standing Sitting Walking Movement Lying down
Rest Massage Elevating area Ice Heat Medications Other:___________

What treatments have you had for the pain: Physical therapy Chiropractic Acupuncture
Massage Trigger Point Injection Epidural Injection Facet Injections Joint Injections
"Gel/Oil" Injection (Knee) TENS unit Back Brace Knee Brace Other:_________________

Does the pain affect your quality of life and/or physical functioning? YES NO
Please explain: ____

How is your sleep: Good Fair Poor

Have you had any tests in past 2 years: MRI CT Xrays Bone Density Bone Scan Other:__________
Where was this done:____

Past Health History/Medical Conditions: ____
____

Past Surgeries / Procedures: ____
____

Drug Allergies: ____

Environmental Allergies (please circle) : Pollen Animal Food Other _____________

Current Medications: (please list all prescription, over-the-counter and supplements along with dosages)
____
____
____
____

Family History: ____
____
____

Social History:

Current Alcohol intake: ___________ Past Alcoholism? _____________ Smoker? ________________________________
Current drug use: ____
Past drug abuse /addiction/ Rehab Issues: ____
General Mood: Good Bad Energy Level from 0 (lowest) to 10 (highest): 0 1 2 3 4 5 6 7 8 9 10
Sleep: Hours/night: ______ Quality of Sleep: Good Poor Dreaming Insomnia Restless
Exercise: ______ hours/week ______ days/week. Describe exercise routine: ____
Diet Style: Meat Vegetarian Vegan Paleo Diabetic High-Cholesterol # meals/day ___________ # snacks/day _______
Preferred Foods: Vegetables Fruits Meat Greasy Sugar Dairy Coffee Tea Alcohol Other ______________
Excessive Thirst: Yes No Prefer to drink: Cold Hot Room Temperature
Occupation: _______________________________________Married____ Single____ Divorced ____ Widowed_____
Level of education: High School___ College____ Graduate School____ Other :___________

Review of Systems:

Do you have any of the following: (circle all that apply)

GENERAL: Changes in appetite or weight, Fatigue, Fever, Chills, Night Sweats, Weakness
MS: Bone Pain, Joint Stiffness, Red/Swollen joints, Deformed joints
Skin: Rashes, Lumps, Acne, Dryness, Discoloration, Changes in hair / nails / moles, Itching, Recurrent skin infections, Skin ulcers, Hypersensitivity
HEENT: Head injury, Visual changes, Double vision, Blurred vision, Earache, Eye pain, Glaucoma, Cataracts, Hearing changes, Runny nose, Toothaches, Hoarseness, Dentures, Ringing in ears, Vertigo, Dizziness, Frequent colds, Nose bleeds
Respiratory: Cough, Coughing up blood, Shortness of breath, Wheezing, Choking or Gasping for air at night, Exposure to Tuberculosis
Cardiovascular: Chest pain, Irregular heartbeat, Palpitations
Gastrointestinal: Abdominal pain, Changes in bowel movements, Constipation, Diarrhea, Heartburn, Blood in stools, Black stools, Nausea, Vomiting, Leakage of stool
Urinary: Pain or burning with urination, Sudden urge to urinate, Trouble starting urination stream, Leaking of urine, Pain in sides, Change in urination
Genital/Reproductive: Sexual difficulties, Painful sexual intercourse
Neurological: Seizures, Tremors, Memory loss
Endocrine: Cold intolerance, Heat intolerance, Excessive sweating, Excessive urination, Excessive thirst
Psychiatric: Anxiety, Sleep disturbance, Irritability, Depression, Mood swings, Suicide thoughts or actions

Height: _____feet, ________inches **Weight:____________________lbs**

I have completed this form & carefully reviewed its contents. I attest to the accuracy & correctness of the information

Patient's Signature: ____

Guardian's signature (if minor):____ Date:__________________

Reviewed by: ____