664 Taunton Ave. Seekonk, MA 02771
508-336-4114

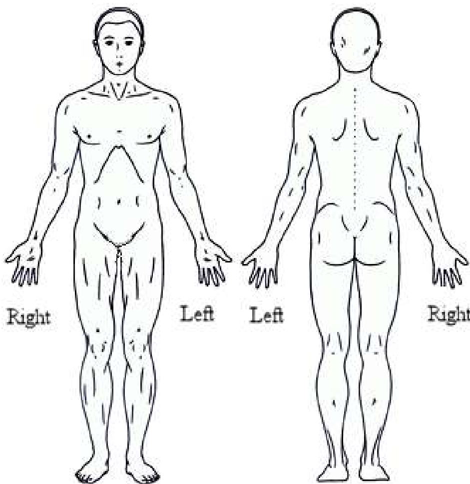
WELCOME TO OUR OFFICE

Date ___________

First__________________________________Last____DOB_________________
Address____City/Town__________________________ State_________ Zip___________
H. Phone ___________________W. Phone______________________ Mobile Phone _________________________
E-mail ____ Preferred communication? Please circle H. Phone W. Phone M. Phone E-mail
Referred by___________________________________ Referred to particular Dr? ____
Marital Status please circle S M D W Spouse's name ______________________________
Emergency Contact _________________________________ Phone _____________________ Relationship _______________________
Are you currently working O Y O N Date stopped ____________________
PCP Name ____________________________________ Address _________________________________ Phone ___________________________

Symptoms and Present State of Health

Present Complaint/Reason for Seeking Care in this Office:
Major____
Is this problem related to an accident? O Y O N If Yes, date of accident _______________ O Auto O WC O Other _________________
Pain or Problem started on____
Pains are: O Sharp O Dull/ Ache O Stiff O Burning O Constant O Intermittent O Other_______________________
Does this pain shoot, radiate, or travel in your body? Where?____
Are you experiencing numbness or tingling in any area of your body? Where?____
Since it began, is it: O Same O Better O Worse
What activities aggravate your condition/pain?____
What activities lessen your condition/pain?____
Is this condition worse during certain times of the day?____
Is this condition interfering with Work?__________ Sleep?__________Routine?_______Other?_______________________
Is this condition progressively getting worse?____
Other Doctors seen for this condition____
Any home remedies? ____
Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Using the symbols below, mark on the pictures where you feel pain.



Numbness = = =

Dull Ache OOO

Burning XXX

Sharp/Stabbing / / /

Pins, Needles + + +

Other ______ ^ ^ ^

Are you under medical care for any condition?____
What Medications are you taking?____
Any known allergies? ____

For the Doctor's use:
Ht: ______________ *Wt:* ____________ *BP:* _______________ *Pulse:* ___________________

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Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	High BP	Other__________________
Father's side	O	O	O	O	O	O
Mother's side	O	O	O	O	O	O

Lifestyle: Are you a smoker? O Y O N If yes, how often? __________ Do you drink alcohol? O Y O N If yes, how often?__________
Do you exercise? O Y O N If yes, how often? __________ Light Moderate Strenuous How much water do you drink? _______ cups/oz
Stress level 1-10 (10 is highest) ________ How many hours do you sleep/night? ________ Sleep posture (circle) side stomach back

Past Health History: Have you had any surgeries? O Y O N Have you ever been hospitalized? O Y O N Have you had any traumas? O Y O N
If yes, please list any details____
____
____

Please mark any of the following conditions or symptoms that you have now or have experienced:

O Recent weight loss O Weight gain
O Headaches O Migraines
O Eye or vision problems
O Ear or hearing problems
O TMJ problems
O Skin trouble or rashes
O Chest pain or tightness
O Shortness of breath
O Palpitations
O Swelling of feet or hands
O High blood pressure
O High cholesterol or triglycerides
O Heart murmur
O Blood clots
O Pacemaker
O Leg pain upon walking
O Easily bruised
O Persistent cough

O Asthma or wheezing
O Sleep apnea
O Nausea or vomiting
O Diarrhea O Constipation
O Abdominal pain
O Difficulty swallowing
O Change in bowel habits
O Gastic reflux
O Dizziness/ Fainting
O Memory loss
O Poor balance
O Numbness or tingling
O Pins and needles
O Stroke
O Tremors
O Anxiety and/or panic
O Depression
O Sleeping issues

O Loss of smell or taste
O Arthritis
O Joint pain or swelling
O Osteoporosis
O Cramping
O Gout
O Anemia
O Insomnia
O Difficulty concentrating
O Agitation/Irritability
O Heat intolerant O Cold intolerant
O Frequent urination
O Excessive thirst
O Change in appetite
O HYPERthyroidism O HYPOthyroidism
O painful or frequent urination
O Blood in urine

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.
Patient Signature____Date__________________________