

ABSOLUTE WELLNESS CENTER

Date: ___ / ___ / ___

Patient name: _____

Age: _____

Areas of complaint: _____

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES

PAIN SCALE

Please circle the number that best describes your pain

0	1	2	3	4	5	6	7	8	9	10	
NONE	LITTLE	MEDIUM					SEVERE				

Please list the dates of any automobile accidents or slip/fall injuries you have been involved in:

Please list the dates of ALL surgical operations and hospitalizations you have had:

Please list ALL medications (Rx and OTC) and any supplements you are taking:

For each of the conditions below place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
		Headaches			Asthma			Constipation
		Neck Pain			Sinus Problems			Chest Pain
		Middle Back Pain			Allergies			Stroke
		Low Back Pain			Fibromyalgia			Heart Disease
		Pain in Arms			Diabetes			Dizziness/Light Headed
		Shoulder Pain			Anemia			Tuberculosis
		Pain in Legs			High Blood Pressure			Hepatitis A B or C
		Foot/Ankle Pain			Epilepsy			AIDS/HIV
		Weakness			Nervousness/Depression			Cancer
		Arthritis			Frequent Urination			Painful Urination
		Numbness/Tingling			Premenstrual Syndrome			Recent Weight Loss/Gain
		Joint Swelling/Stiffness			Kidney Stones			Other _____

FEMALES: LMP _____ Pregnant? _____ Nursing? _____ Breast implants? _____

I certify with my signature that the information above is true and complete to the best of my knowledge. I also acknowledge that I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient/Guardian Signature _____

Date: _____