MUSCULOSKELETAL OVERVIEW: please check all present symptoms

HEAD:
☐ Headache
    ☐ sinus (allergy)
☐ entire head
    ☐ back of head
    ☐ forehead
    ☐ temples
    ☐ migraine
☐ Head feels heavy
☐ Loss of memory
☐ Light-headedness
☐ Fainting
☐ Light bothers eyes
☐ Blurred vision
☐ Double vision
☐ Loss of vision
☐ Loss of taste
☐ Loss of balance
☐ Dizziness
☐ Loss of hearing
☐ Pain in ears
☐ Ringing in ears
☐ Buzzing in ears

MID-BACK:
☐ Mid-back pain
☐ Location
☐ Pain between the shoulder blades
☐ Sharp/stabbing
☐ Dull ache
☐ Pain from front to back
☐ Muscles spasms
☐ Pain in the kidney area

LOW BACK:
☐ Low back pain
    ☐ Upper lumbar
    ☐ Lower lumbar
    ☐ Sacroiliac
☐ Low back pain is worse when:
    ☐ working
    ☐ lifting
    ☐ stooping
    ☐ standing
    ☐ sitting
    ☐ bending
    ☐ coughing
    ☐ lying down (sleeping)
    ☐ walking
☐ Pain relieves when:_________
☐ Slipped disk
☐ Low back feels out of place
☐ Muscle spasms
☐ Arthritis

NECK:
☐ Pain in neck
☐ Neck pain with movement
☐ Forward
    ☐ Backward
    ☐ Turn to left
    ☐ Turn to right
    ☐ Bend to left
☐ Bend to right
☐ Pinched nerve in neck
☐ Neck feels out of place
☐ Muscle spasms in neck
☐ Grinding sound in neck
☐ Popping sound in neck
☐ Arthritis in neck

SHOULDERS:
☐ Pain in shoulder joint (R-L)
☐ Pain across shoulders
☐ Bursitis (R-L)
☐ Arthritis (R-L)
☐ Cannot raise arm
☐ above shoulder level
    ☐ over head
☐ Tension in shoulders
☐ Pinched nerve in shoulder (R-L)
☐ Muscle spasms in shoulders

CHEST:
☐ Chest pain
☐ Shortness of breath
☐ Pain around the ribs
☐ Breast pain
☐ Dimpled or orange peel breast
☐ Irregular heartbeat

HIPS, LEGS, & FEET:
☐ Pain in buttocks (R-L)
☐ Pain in hip joint (R-L)
☐ Pain down leg (R-L)
☐ Knee pain
    ☐ inside
    ☐ outside
☐ Leg cramps
☐ Cramps in feet (R-L)
☐ Pins/Needles in legs (R-L)
☐ Numbness of leg (R-L)
☐ Numbness of feet (R-L)
☐ Numbness of toes (R-L)
☐ Feet feel cold
☐ Swollen ankles (R-L)
☐ Swollen feet (R-L)

ARMS & HANDS:
☐ Pain in upper arms
☐ Pin in elbow
☐ Movement aggravated
☐ Tennis Elbow
☐ Pin in forearms
☐ Pain in hands
☐ Pain in fingers
☐ Sensation of pins/needles in arms
☐ Sensation of pins/needles in fingers
☐ Numbness in arms (R-L)
☐ Numbness in fingers (R-L)
☐ Fingers go to sleep
☐ Hands cold
☐ Swollen joints in fingers
☐ Sore joints in fingers
☐ Arthritis in fingers
☐ Loss of grip strength

ABDOMEN:
☐ Nervous stomach
☐ Foods can't eat _____________
☐ Nausea
☐ Gas
☐ Constipation
☐ Diarrhea
☐ Hemorrhoids

MEN ONLY:
☐ Urinary frequency
☐ Difficulty in starting
☐ Night urination
☐ Prostate pain/swelling

WOMEN ONLY:
☐ Menstrual pain/location________
☐ Cramping
☐ Irregularity
☐ Cycle_______days
☐ Birth control___________type
☐ Hysterectomy
☐ Menopause
☐ Are you or do you think you might be pregnant?____

ADDITIONAL COMMENTS:
____
____
____
____
____
____
____
____
____
____
____

MEDICAL HISTORY

Name:________________________________Date:_______________________________

Past Medical History:
Please indicate whether you currently have or have had any of the following conditions:
☐ Tumor or cancer
☐ Heart Disease or heart attack
☐ High Blood Pressure
☐ Diabetes
☐ Thyroid Disease
☐ Asthma
☐ Stroke
☐ Arthritis
☐ Autoimmune disease
☐ Herpes simplex
☐ Epstein Barr Virus
☐ HIV virus
☐ Epilepsy or convulsions
☐ Kidney or bladder problems
☐ Pneumonia or emphysema
☐ Tuberculosis
☐ Jaundice
☐ Hepatitis
☐ Peptic Ulcer or pancreatitis
☐ Anemia
☐ Hernia
☐ Venereal Disease
☐ Congenital abnormalities
☐ Rheumatic fever
☐ Do you have a pacemaker?
☐ Surgical implants?

Family History:
Has any blood relative had any of the following: Father (F), Mother (M), Brother (B), Sister (S):
______Stroke
______High Blood Pressure
______Cancer
______Tuberculosis
______Diabetes
______Osteoporosis
______Alzheimer's
______Mental Illness

Surgeries/Hospitalizations:
Please list all previous operations and date of procedure:

Other serious illnesses, injuries, or fractures:

Allergies: *please list any food, drug or other allergens:*

Current Medications:
Please list prescription or over T*he counter medications:*

Do you frequently take or use:
______Pain Relievers

______Antacids

______Laxatives

______Sleeping Pills

______Tranquilizers

Vitamins & Supplements:
List any vitamins, herbs, minerals, etc...

Diet/Lifestyle:

Do you smoke?_________
Use drugs?____________
Number of alcoholic drinks/week?
____
How much coffee?
____

Exercise?_____________
What?_____________
Frequency?_________
Fatigue?______________
Generally feel run down?_____________
Normal sleep?__________
Loss of sleep?__________
Loss of weight?_________
Weight gain?___________

Food:
Sweets?______________
Fried Food?____________
Vegetarian?____________
Cravings?_____________

Other?________________