Comprehensive History, Consult, and Evaluation Form

1.Patient Information: Today's Date: _____

□Mr. □Ms. □Miss □Mrs. □ Dr. Name_____

Age: _____ Date of Birth: _____ □Male □Female

Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____ _____

Cell Phone: _____ E-Mail: _____

Employed By:

_____

Physician Name & Address: _____

Referred By:

_____

What are the reasons for your visit today?

_____
_____
_____
_____
_____
_____
_____

When did your symptoms start?

_____
_____
_____
_____
_____

What do you believe is the cause of your pain or present condition?

_____
_____
_____
_____
_____

How does your present condition affect your quality of Life? Have you had to change the way you do things or eliminate certain activities from your life?

_____
_____
_____
_____
_____
_____
_____

Has anyone in your family had a similar condition to what you are experiencing now? If so, who?

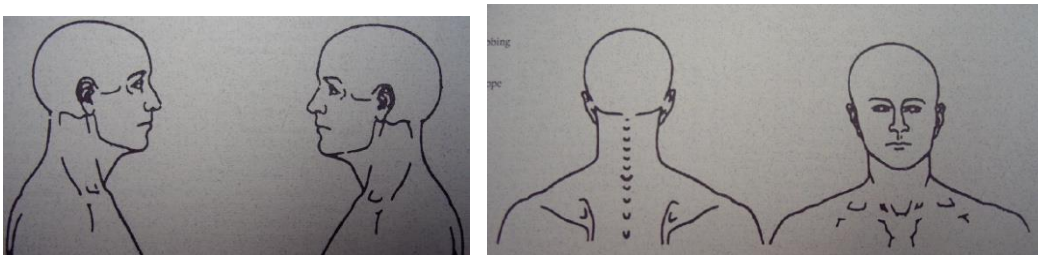
_____

1. **Please rank your complaints in order of severity with #1 being the most severe complaint, #2 the next, etc.**

2. Then rate your complaints for **frequency**, **intensity**, and **duration**.

RANK OF COMPLAINT	COMPLAINT	FREQUENCY (1-4) 1)seldom, 2)occasional 3)frequent, 4)every day	INTENSITY (0-10) 0=no pain 10=severe pain	DURATION 1)Min., 2)Hrs, 3)Days, 4)Constant
	Back Pain			
	Dizziness			
	Ear Congestion			
	Ear Pain			
	Eye Pain			
	Facial Pain			
	Fatigue			
	Grind Teeth			
	Headaches			
	Jaw Clicking			
	Jaw Joint Noises			
	Jaw Locking			
	Jaw Pain			
	Limited Mouth Opening			
	Migraines			
	Muscle Soreness			
	Muscle Twitching			
	Neck Pain			
	Pain when Chewing			
	Ringing in the Ears			
	Shoulder Pain			
	Sinus Congestion			
	Throat Pain			
	Visual Disturbances			
	Other (write in)			

Place an X anywhere on the diagram where you experience pain.



List of Health Care Providers:

List the name, area of specialty, and address of all healthcare providers that are currently taking care of you. This should include, but is not limited to, primary care Physician, ENT, Neurologist, Rheumatologist, Dentist, Chiropractor, Physical Therapist, Acupuncturist, Nutritionist, Psychiatrist, Psychologist, Massage Therapist, etc. :(attach an additional sheet if necessary)

1._____
_____
2._____
_____
3._____
_____
4._____
_____
5._____
_____
6._____
_____

List all previously diagnosed medical conditions: (attach additional sheet if more space is needed)

1._____
2._____
3._____
4._____
5._____
6._____

List all traumatic injuries or accidents, and when they occurred from childhood until the present: (examples: car accident, work related accident, fall, fight, athletic endeavor): (attach additional sheet if more space is needed)

1._____
2._____
3._____
4._____
5._____
6._____

List all surgeries, when they occurred, and who performed them: (attach additional sheet if more space is needed)

1._____
2._____
3._____
4._____
5._____
6._____

Do you, or have you ever used tobacco products? ◯no, ◯yes. If yes, explain: (type, years of use, use per day)

_____

Do you exercise regularly? Explain:

_____

What is your daily caffeine exposure? (coffee, tea, soda, energy drinks, etc.- cups, cans, bottles, etc./day)

_____

On average, how many hours of sleep do you get per night? _____

Do you wake up in the middle of the night? ◯no, ◯yes. If yes, how often, and for what reason?

_____

Do you use sleeping aids in order to get a sound sleep? ◯no, ◯yes. If yes, please explain: (medications, CPAP, mouth appliances, nasal strips, sound therapy, light therapy, other):

_____

Do you snore? ◯no, ◯yes

Have you been diagnosed with sleep apnea or have you ever been told that you stop breathing for periods of time while you are sleeping? ◯no, ◯yes. If yes, please explain:

_____

Do you wake up feeling refreshed? ◯no, ◯yes. If no, please explain:

_____

Emotional Factors: (circle all that apply and explain below)

a. Negative attitude b. Anxious c. Depressed d. Frustrated

e. Nervous f. Fatigue g. Job Stress h. Personal problems

_____
_____
_____
_____
_____

List all allergies:

1._____
2._____
3._____
4._____
5._____
6._____

List of medication:

Prescription medications: List all prescription medications, dosage, when in the day you take it, and who prescribed it: (attach additional sheet if more space is needed)

1._____
2._____
3._____
4._____
5._____
6._____

Non-prescription medications, vitamins, supplements, etc.: (attach additional sheet if more space is needed)

1._____
2._____
3._____
4._____
5._____
6._____

List all health care providers that you have seen **for your present condition**. Include their area of specialty, treatment provided, effectiveness of treatment, and date of treatment: (effectiveness scale 0-3 where 0=not effective and 3=very effective)

	Provider Name	Specialty	Treatment Rendered	Effectiveness	Date
A					
B					
C					
D					
E					

F					
G					
H					

Describe duties at your place of employment. _____

_____

_____

_____

Do your work responsibilities include any of the following (check all that apply):

□ prolonged computer use □ heavy lifting □ prolonged standing

□ extended driving □ awkward body positioning □ prolonged phone use

Please list your leisure time activities, hobbies, and physical activities:

_____

_____

_____

_____

_____

_____

Musculoskeletal: Osteoarthritis: □ yes □ no

Rheumatoid Arthritis: □ yes □ no

Fibromyalgia: □ yes □ no

Other: _____

Circulatory: Vascular disease: _____

Heart disease_____

Blood Disorders: _____

Ear-Nose-Throat:

Hearing Loss: □ right □ left _____

Surgical History: _____

Sinusitis: □ yes □ no

Other: _____

Headache: □ yes □ no

Have your headaches ever been diagnosed as: □ Migraine □Cluster □ Tension Other: _____

_____

How often: Times/week_____ Daily_____ Other: _____

Duration of episodes: _____

Location: _____

Is there a pattern to onset: □on rising □late afternoon □waken in night □menses

□weather related _____

Response to medications: _____

In recent months have the headaches:

Frequency: □increased □decreased □unchanged

Duration: □increased □decreased □unchanged

Intensity: □increased □decreased □unchanged

Headaches associated with:

Nausea: □yes □no

Blurred vision: □yes □no

Excessive tearing: □yes □no

Toothache: □yes □no which teeth: _____

Other associated symptoms: _____

Muscle Aches:

Neck Pain: □none □mild □moderate □severe □intermittent □constant

Place √ in appropriate box.

Left							Right					
INTMT.	CNST.	MILD	MOD.	SEV.	NONE		NONE	SEV.	MOD.	MILD	CNST.	INTMT.
						SHOULDER						
						UPPER BACK						
						LOWER BACK						
						HIP						
						THIGH						
						CALF						

Numbness or diminished sensation in:

Fingers: □yes □no Describe: _____

Hands: □yes □no □left □right Describe: _____

_____

Arms: □yes □no Describe: _____

Elsewhere: □yes □no Describe: _____

Oral/Facial:

Jaws clenched upon awakening: □yes □no

Clenching & grinding during sleep: □yes □no

Clenching & grinding during waking hours: □yes □no

Facial muscle fatigue: □yes □no Describe: _____

Facial muscle pain: □yes □no Describe: _____

_____

Nasopharyngeal (nose/throat):

Chronic Sinusitis: □yes □no

Chronic stuffy nose: □yes □no

Chronic nasal discharge: □yes □no

Post nasal drip: □yes □no

Do you suffer from allergies: □yes □no which ones: _____

_____

Do you receive allergy shots or medications: □yes □no Describe: _____

_____

Are your nasopharyngeal allergy symptoms: □constant □intermittent □seasonal

EAR:

Tinnitus (ringing in ears): Right: □yes □no □constant □intermittent

Left: □yes □no □constant □intermittent

Ear Pain: Right: □yes □no □constant □intermittent

Left: □yes □no □constant □intermittent

Stuffiness Sensation: Right: □yes □no □constant □intermittent

Left: □yes □no □constant □intermittent

Loss in hearing acuity: □yes □no □severe □mild □gradual □sudden

First noticed change: _____

□worsening □same

Vertigo (feeling of moving around in space or objects spinning around you):

□yes □no when: _____