PATIENT CLINICAL SYMPTOMS RECORD

Patient Name: _____ **Date of Visit**_____

CHECK THE SYMPTOMS YOU HAVE NOTICED

___Headache
___Neck pain
___Neck stiff
___Sleeping difficulties
___Lower back pain
___Upper back pain
___Nervousness
___Fever
___Loss of smell
___Loss of taste
___Diarrhea
___Stomach upset
___Dizziness
___Head seems heavy
___Pins/needles – Arm
___Pins/needles – Leg
___Numbness in Fingers
___Numbness in Toes
___Tension
___Irritability
___Chest pain
___Feet cold
___Constipation
___Limping
___Light hurts eyes
___Loss of memory
___Ears Ring
___Face flushed
___Buzzing in ears
___Loss of balance
___Shortness of breath
___Fatigue
___Depression
___Hands cold
___Cold sweats
___Weak grip

Additional symptoms: _____
_____

Are you currently seeing another doctor for care of your present symptoms? ___Yes ___No
If Yes, Whom?_____

PAST MEDICAL HISTORY

Have you ever had any of these Diagnoses or Medical Conditions?
Please take time to review and check off any that apply to you.

___Heart Attack/Stroke
___Congenital Heart Defect
___High/Low Blood Pressure
___HIV/AIDS
___Fainting/Seizures/Epilepsy
___Diabetes
___Rheumatoid Arthritis
___Anemia
___Chronic Neck Pain
___Tuberculosis
___Artificial Bones/Joints
___Emphysema/Glaucoma
___Back/Neck Surgery
___Murmur
___Artificial Valve
___Rheumatic Fever
___Shingles
___Chronic Low Back Pain
___Kidney Problems
___MRI
___Cancer
___Chemotherapy
___GastricUlcers/Colitis
___Heart Surgery/Pacemaker
___Psychiatric Problems
___Mitral Valve Prolapse
___Difficulty Breathing

If any of the above are checked off, please explain:_____

Any recent accidents or falls? _____

List all Previous Surgeries: _____

Other Illnesses:_____

List all Medications/Supplements Currently Being Taken:_____

_____