**Name:** _____ **Age:** _____ **Date:** _____

**Chart Number:** _____ **Birth Date:** _____

**Reason for today's visit:** _____

**Allergies:** _____

**Medications:** _____

Has there been any response to treatment?: _____

VITALS: B/P: _____ Temp: _____ Resp Rate: _____ Pulse Rate: _____

Height: _____ Weight: _____ Pain (Rate 1 – 10): _____

REVIEW OF SYSTEMS:

**Please circle or place an "x" next to any of the following conditions you might have now.**

___ Taking blood thinners
___ Arthritis
___ Diabetes
___ Infections
___ Thyroid disorders
___ Lupus
___ Insomnia / Trouble sleeping
___ Depression
___ Anger
___ Weight loss or gain
___ Eye, ear, nose, throat, lung, heart, stomach, kidney or skin disorders (please circle)
___ Stroke
___ Unusual stress in home life
___ Skin rashes
___ Headaches
___ Family dysfunction
___ Fibromyalgia
___ Nausea
___ Vomiting
___ Chills
___ Problems with sexual function
___ Loss of sensation around groin or buttocks
___ Unexplained fevers
___ Night sweats
___ Loss of appetite
___ Excessive fatigue
___ Decreased concentration
___ Memory difficulties
___ Unusual stress in work life
___ Trouble breathing with exercise
___ Trouble breathing lying flat
___ Stomach pain
___ Constipation
___ Swollen ankles
___ Joint pain or swelling
List joints _____
___ Muscle tenderness
___ Generalized morning stiffness
___ Blood in stool
___ Pain or burning when urinating
___ Blood in urine
___ Need to urinate more at night
___ Dry eyes or mouth

Any changes in personal medical history, family medical history, or social history since your last visit with Dr. Robinson/Dr. Tiffany?

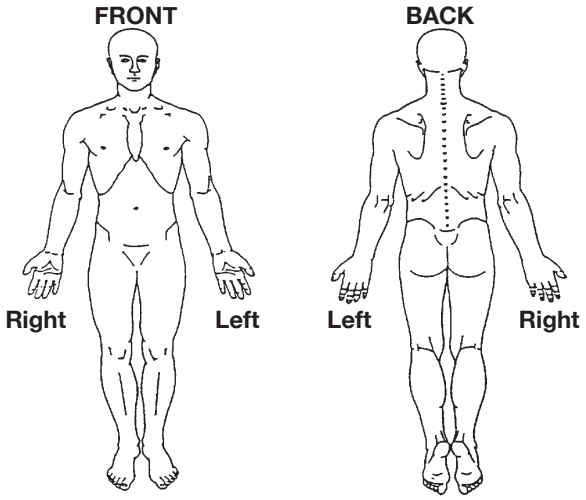
No_____ Yes_____:_____

*(please let the receptionist know if you would like to review your initial responses)*

USING THE SYMBOLS IN THE KEY, INDICATE TYPE AND AREA OF DISCOMFORT ON THE BODY DIAGRAMS.

**KEY:**

| | |
|---|---|
| Numbness | ======== |
| Pins & needles | oooooooooo |
| Ache | ^^^^^^^^^^ |
| Burning | XXXXXXXX |
| Stabbing | ////////////// |




_____

Patient's Signature

**ASSESSMENT:**

1._____
2._____
3._____

Follow up _____ (day, week, month, as needed)

_____

Physician Signature

**PLAN:**

1._____
2._____
3._____

_____

Date