PRE-TREATMENT HISTORY (Male)

Last name:_____**First name:**_____ Age:_____

Preferred to be addressed as (name):_____Date of Birth: ____/____/_____

Address:_____ Zip Code_____

Phones Home: (___)____-_____Work: (___)____-_____Mobile:(___)____-_____

Occupation: _____Weight _____ Height _____

E-mail Address_____

Primary Physician: Name_____ Phone: (___)____-_____

Address:_____

Please list and rate (on a scale from 1 to 10) your 5 top symptoms as indications for treatment:

	Symptoms	Rate
1).	_____	_____
2).	_____	_____
3).	_____	_____
4).	_____	_____
5).	_____	_____

How do you rate your nutrition:_____

Any other symptoms you experience, which are not listed: _____

Medications :(currently taken)_____

_____

_____

Supplements:(currently taken)_____

_____

_____

Past medical history:

Please circle if you were diagnosed with any of these:

Heart disease/Heart attack High Blood Pressure Lipid disorder Blood clots

Stroke/Seizures Headache Glaucoma Thyroid disease Osteoporosis/Weak bones

Lung disease Shortness of breath Asthma Emphysema Bronchitis

Stomach/Hepatitis/Intestinal problems/ Kidney disease HIV/AIDS Phlebitis

Diabetes Immune disorder Blood disorder Prostate cancer

Have you ever had elevated PSA? Please explain_____

Others (not listed) _____

Family History: please list your parents' health problems

Father_____

_____

Mother_____

_____

Have you ever had any unexpected local anesthesia problems? _____

Have you ever been under the care of a psychiatrist? _____

Are you involved in any medical litigation?
Describe:_____

Surgical History:

Please list your surgeries: _____

_____

_____

Allergies: _____

Adverse reaction to the medications(if any)_____

Social History:

Do you exercise? _____ How many times per week?_____

Do you smoke/if yes, how much? _____ Alcohol? How much? _____

Are you currently seeing any of the following: Please Circle Below

Pain Specialist Name_____ Telephone_____

Weight Management Name_____ Telephone_____

Chiropractor Name_____ Telephone_____

Is the above information true and complete? YES or NO

Signature_____ Date:_____

Notes:

_____

_____

_____