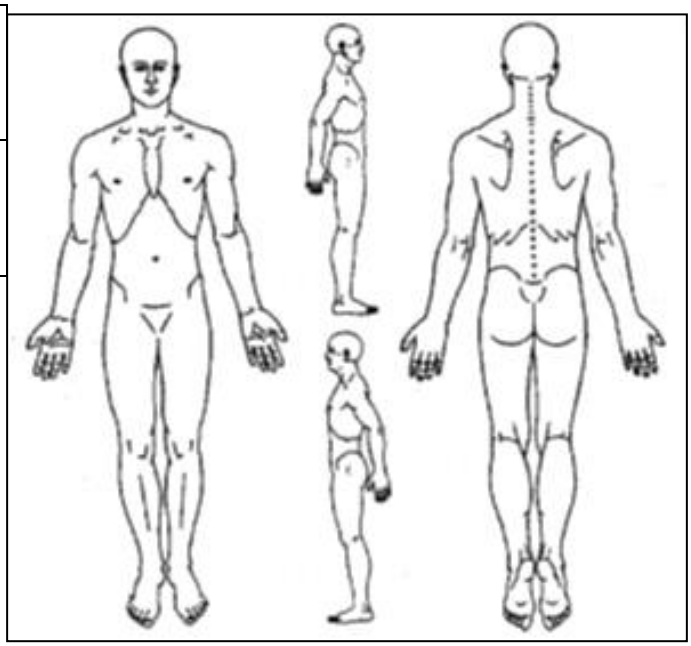
MaxFit Movement Institute

Patient Name: _____ Date: _____

Reason(s) for todays visit

Please use the diagram right to mark the area of your body that you feel best represents the pain/sensation you are currently experiencing.

Numbness: = = =	Dull/aching: o o o
Sharp/Stabbing: > > >	Burning: x x x
Pins & Needles: ? ? ?	Stiff/tight: 2 2 2



When did this begin? _____

What were you doing? _____

Have you experienced this before? Yes ☐ No ☐

Have you lost work days?

Yes ☐ How many? _____ No ☐

How would you describe it?

Improving ☐ Staying the same ☐ Worsening ☐

Medical History

Medical Conditions	Medications	Allergies

Lifestyle factors

	Alcohol	Coffee	Tobacco	Exercise	Sleep	Appetite	Recreation	Supplements
Heavy								
Moderate								
Light/None								

Please Turn Over

*Please note: If you are seeing more than one practitioner, we can share this information for your convenience.

Please "X" Any conditions that are presently causing you a problem and underlying conditions that have caused any problems in the past.

General Symptoms

- ☐ Fever
- ☐ Excessive sweating/night sweats
- ☐ Loss of consciousness
- ☐ Headache
- ☐ Fatigue
- ☐ Nervousness
- ☐ Weight loss
- ☐ Night pain
- ☐ Loss of sleep

Skin

- ☐ Rashes
- ☐ Itching
- ☐ Dryness
- ☐ Easily Bruising
- ☐ Boils
- ☐ Hives/Allergies
- ☐ Changes in moles or skin markings

Genitourinary

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Prostate trouble
- ☐ Trouble starting urine flow
- ☐ Uncontrolled urine flow
- ☐ Bedwetting

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Bleeding disorder
- ☐ Stroke
- ☐ Hardened arteries
- ☐ Heart/blood disease
- ☐ Anemia
- ☐ Palpitations/Racing heart
- ☐ Angina
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

Respiratory

- ☐ Asthma
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Wheezing
- ☐ Difficulty breathing
- ☐ Shortness of breath

Smoking? Y/N

Previously? Y/N

Genitourinary for women

- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular/absent cycle
- ☐ Cramping/backache
- ☐ Vaginal discharge
- ☐ Nipple discharge
- ☐ Swollen breasts
- ☐ Lumps in breasts
- ☐ Menopause symptoms
- ☐ Pregnancy complication/miscarriage

Pregnant: Y/N Week:

Eyes/Ears/Nose/Throat

- ☐ Failing vision
- ☐ Eye pain
- ☐ Failing hearing
- ☐ Ear ache
- ☐ Ring/buzzing in ears
- ☐ Frequent colds
- ☐ Sinus infection
- ☐ Enlarged thyroid
- ☐ Enlarged glands
- ☐ Hoarseness
- ☐ Nasal drainage
- ☐ Nosebleeds

Muscle & Joint

- ☐ Neck pain
- ☐ Back pain
- ☐ Tailbone pain
- ☐ Shoulder pain
- ☐ Arm/forearm/elbow pain
- ☐ Wrist/Hand pain
- ☐ Hip/leg pain
- ☐ Knee pain
- ☐ Ankle/foot pain
- ☐ Swollen joints
- ☐ Arthritis

Neurological

- ☐ Blurred vision
- ☐ Double vision
- ☐ Dizziness
- ☐ Fainting
- ☐ Convulsions
- ☐ Problem Speaking
- ☐ Problem Swallowing
- ☐ Numbness & tingling
- ☐ Clumsiness
- ☐ Weakness

Gastrointestinal

- ☐ Poor appetite
- ☐ Indigestion/heartburn
- ☐ Excess hunger
- ☐ Belching/gas
- ☐ Nausea/vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids (piles)
- ☐ Red or tarry stool
- ☐ Gallbladder trouble
- ☐ Jaundice
- ☐ Ulcer

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