Cata*lyst* WELLNESS

Confidential Patient Information

Patient Full Name:_____ Date:_____/_____/_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ E-Mail:_____ Date of Birth: ____/____/_____

Gender: M / F Married: Y / N Spouse's Name: _____ # of children_____

Height:_____Weight:_____ Occupation: _____ Employer:_____

How did you hear about our office?_____

Emergency Contact:_____ Phone:_____

Current Health History

Chief Complaint: _____

Date of Onset:_____ Have you had this problem before? Y / N When?_____

What caused the pain?_____

How much do your symptoms limit daily life? None - Mild - Moderate - Limiting - Intense - Severe _____

How often does the pain occur in the past 24 hours? 0-25% / 25-50% / 50-75% / 75-100%

What makes the pain better?_____

Better: In the morning - The evening - Gets better throughout the day - Stay the same - With activity - Sitting - Standing

What makes the pain worse?_____

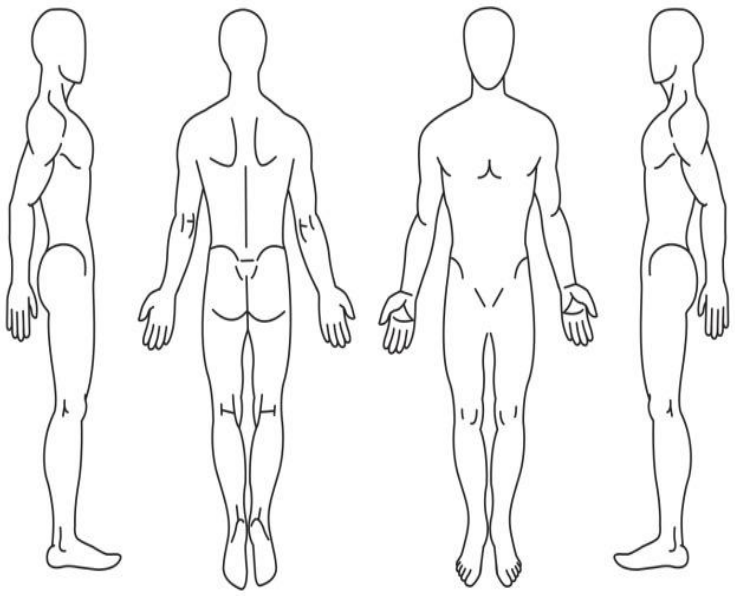
Worse: In the morning - The evening - Gets worse throughout the day - Stay the same - With activity - Sitting - Standing

Does the pain travel to any other areas? _____

Best describe your pain: Throbbing - Ache - Dull - Sharp - Shooting - Burning - Deep - Pressure - Numb - Tightness

Label the location and quality of your symptoms.	
A=Ache	D=Dull
B=Burning	S=Sharp
N=Numbness	T=Tingling

Pain Scale										
Circle the number that best describes your pain.										
0	1	2	3	4	5	6	7	8	9	10
None		Mild		Moderate			Severe			



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Does this condition affect your sleep? Y / N Sleeping position? - Stomach - L Side - R Side - Back _____

Have you missed work due to this complaint? Y / N _____

Previous treatment for this condition? Y / N _____

Imaging Performed? (X-Ray, MRI, etc.) _____

Do you have a secondary complaint?_____

History of cancer: Y / N _____ Unexplained weight loss: Y / N _____

History of trauma: Y / N _____ Imaging: Y / N _____

Recent / relevant surgery: Y / N _____ History of stroke? Y / N _____

History of heart attack? Y / N _____ Hospitalizations? Y / N _____

What activity(ies) are your symptoms limiting you? _____

Family/Primary Physician:_____ Date of Last Physical Exam:_____

Physician contact:_____

List current medications and supplements:

_____

_____

_____

_____

Are you pregnant, or think you are pregnant (Female only)? Y / N - Birth Control? Y / N _____

List any health conditions you have been diagnosed and/or treated for in the last year: _____

_____

Do you have FAMILY history of: Cancer - Heart Disease - Arthritis - Diabetes - Other _____

_____

Do you exercise? Y / N _____ times / week What kind? _____

Do you smoke? Y / N _____ packs/ day - How much alcohol do you consume? _____

Do you eat a balanced diet? Y / N - Do you get adequate sleep? Y / N - Is work/family stressful? Y / N

_____

_____

_____

_____

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Cardiovascular	None Below _____		
	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurysm			
Heart Disease			
Vascular Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pacemaker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

Genitourinary	None Below _____		
	Present	Past	No
Kidney Disease			
Burning Urination			
Frequent Urination			
Blood in Urine			
Kidney Stone			

Respiratory	None Below _____		
	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Eyes	None Below _____		
	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

Ears/Nose/Throat	None Below _____		
	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			
Tubes			

Integumentary	None Below _____		
	Present	Past	No
Skin Lesions			
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

Allergic/Immune	None Below _____		
	Present	Past	No
Hives			
Immune Disorder			
HIV / AIDS			
Allergy Shots			
Seasonal Allergies			

Gastrointestinal	None Below _____		
	Present	Past	No
Gallbladder			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Bloody Stools			
IBS / Crohn's			

MusculoSkeletal	None Below _____		
	Present	Past	No
Gout			
Arthritis			
Osteoporosis			
Broken Bones			
Joints Replaced			
Cortisone			

Endocrine	None Below _____		
	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopause			
Menstrual Problems			

Psychiatric	None Below _____		
	Present	Past	No
Depression			
Anxiety			
Unusual Stresses			
Eating Disorders			

Constitutional	None Below _____		
	Present	Past	No
Unusual Weight loss/gain			
Poor Energy Level			
Difficulty Sleeping			

Neurological	None Below _____		
	Present	Past	No
Stroke			
Seizure			
Head Injury			
Aneurysm			
Parkinson's			
Numbness			
Poor Balance			

Please read and sign:

I hereby state that all the information that I have provided to Catalyst Wellness, LLC is complete and truthful and that I fully disclosed my health History.

Patient or Guardian Signature: _____ Date: _____