ADVANCED
61 Beaver Brook Road, Lincoln Park, NJ 07035

MEDICAL HISTORY

Patient's Name:_____

Reason for visit:_____

When did your symptoms first appear? _____

Is this condition getting progressively worse or better? _____

Rate the severity of your pain on a scale from 1(least pain) to 10 (severe pain): _____

Type of pain: ____Sharp ____Dull ____Throbbing ____Numbness ____Aching ____Shooting ____Burning
____Tingling ____Cramps ____Stiffness ____Swelling Other: _____

How often do you have pain/symptoms? _____

Is it constant or does it come and go? _____

Does it interfere with your ____Work ____Sleep ____Daily Routine ____Recreation

Activities or movements that are painful to perform: (circle all that apply)

Sitting Standing Walking Bending Lying Down

What medical treatments have you already received for your condition? (circle all that apply)

Medication Surgery Physical Therapy Chiropractic Other: _____

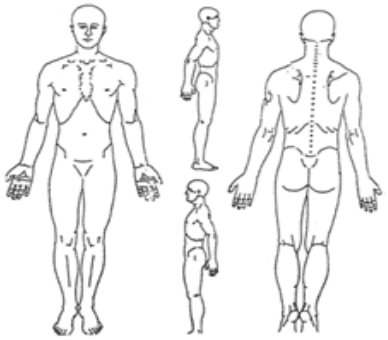
Have you fallen in the past 12 months? Yes ____ No____ If yes, how many times? _____

Allergies	Medications	Dosage / Frequency	Vitamins/Herbs/Minerals
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Exercise Level	Work Activity	Habits
____None	____Sitting	____Smoking
____Moderate	____Standing	____Alcohol
____Daily	____Light Labor	____Coffee/Caffeine
____Heavy	____Heavy Labor	____High Stress Level

Are you pregnant? ___No ___Yes If yes, due date: _____

Mark areas of pain below.



Injuries / Surgeries

	Description	Date
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Falls	_____	_____
Other Injuries	_____	_____

Please indicate if you have had any of the following: (circle)

Anemia	Goiter	Multiple Sclerosis	Prosthesis
Arthritis	Gout	Osteoporosis	Rheumatoid Arthritis
Asthma	Heart Disease	Pacemaker	Scarlet Fever
Cancer	Hernia	Parkinson's Disease	Stroke
Diabetes	High Cholesterol	Pinched Nerve	Seizures
Epilepsy	Migraine Headaches	Polio	Tumors

Other: Please Specify: _____

Patient's Signature_____ Date: _____