Dr. Joseph D. Miller, D.C.

1931 Welby Way, Suite 1
Tallahassee, FL 32308
(850) 580-5252 * Fax (850) 878-8400

304 W 9th Ave Ste 14
Havana, FL 32333
850-580-5252

Patient Name: _____ DOB: _____ Age: _____

Primary Care Physician: _____ Date_____

HISTORY OF PRESENT ILLNESS (HPI):

What is the **PRIMARY** reason for your visit? (Pain/ Complaint)_____

_____

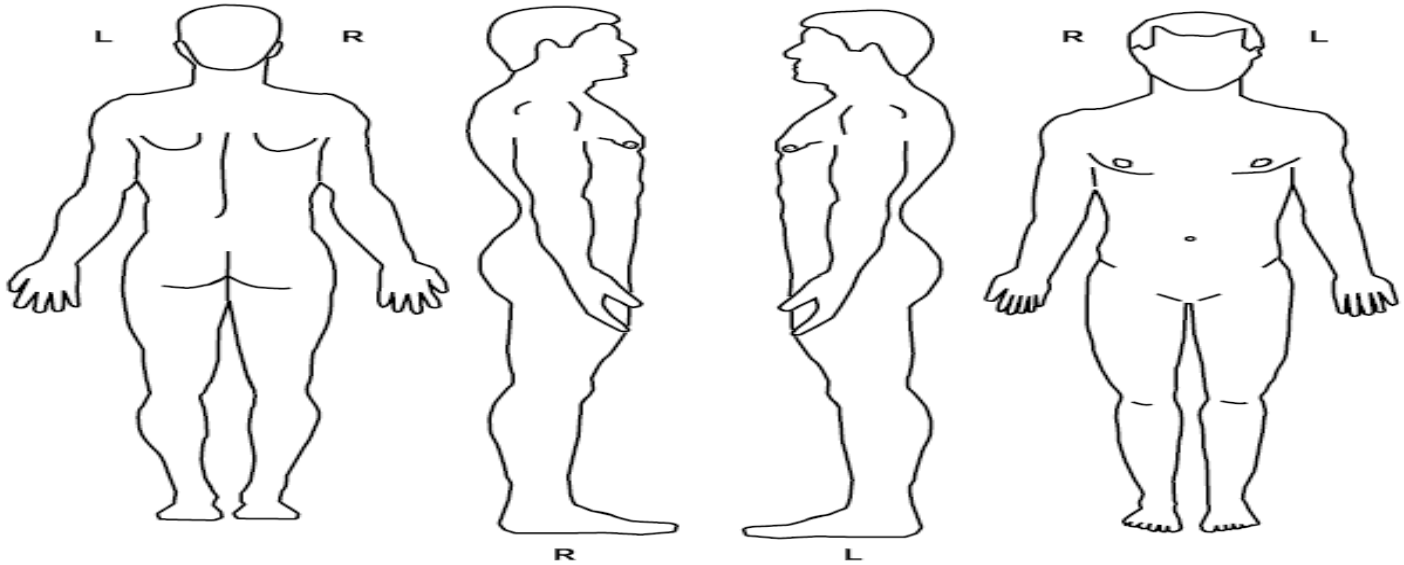
_____

_____

Mark area(s) of injury or PAIN. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from **0 (NO PAIN) to 10 (Extreme pain). 0 1 2 3 4 5 6 7 8 9 10**

If necessary, describe your symptoms in words off to the side.

Description:	**Aching**	**Numbness**	**Pins & Needles**	**Burning**	**Stabbing**	**Throbbing**
Symbol:	**A**	**N**	**P**	**B**	**S**	**T**



What **CAUSED** this problem /**Auto Injury/ Work Injury/ Sport Injury/ Other** _____

_____

When did this problem begin? (Day, Week, Month, Year) _____

Have you had this problem before? YES NO

Is the Condition getting: BETTER / WORSE / SAME

What makes this problem **BETTER**? _____

What makes this problem **WORSE**? _____

Have you had imaging performed for your symptoms? YES / NO What type? Xray MRI CT-Scan

When?_____Where?_____

What do your symptoms interfere with? Work / Sleep / Daily Routine / Recreation / Exercise

Other:_____

Is your pain: Constant / Comes and goes / Other_____

How often do you experience your symptoms Daily / Weekly / Monthly etc:_____

Do your symptoms wake you up at night**: YES** / **NO**

Do your symptoms stay in one place or does it **TRAVEL** (radiate) to another area of your body? **YES NO**
Where? _____

What treatment have you tired for your condition? **(CIRCLE ANSWER)**
Medication / Surgery / Physical Therapy / Chiropractic / Massage / Pain management / Acupuncture / None

Name of other doctor(s)/ therapists seen for this condition and outcome: _____
_____

Do you use a cervical pillow or lumbar support at home or office?_____

Do you have flat feet or foot related pain?_____
_____

Describe any **Secondary** problem:
_____
_____
_____
_____
Onset Date:_____
What makes it better:_____
What makes it worse:_____
Do your symptoms radiate or travel:_____
Quality of your symptoms :**Aching / Numbness /Pins & Needles / Burning / Stabbing /Throbbing: Other**
Severity of symptoms 0-10 with ten being the most pain_____
How often do you have your symptoms**:**_____

Describe any **Tertiary** problem:
_____
_____
_____
_____
Onset Date:_____
What makes it better:_____
What makes it worse:_____
Do your symptoms radiate or travel:_____
Quality of your symptoms :**Aching / Numbness /Pins & Needles / Burning / Stabbing /Throbbing: Other**
Severity of symptoms 0-10 with ten being the most pain_____
How often do you have your symptoms**:**_____

REVIEW OF SYSTEMS: PLEASE MARK WITH C= CURRENTLY or P= PAST

GENERAL SYMPTOMS
___ Headache
___ Weight Loss
___ Fever
___ Chills
___ Night Sweats
___ Fainting
___ Dizziness
___ Convulsions
___ Loss of Sleep
___ Fatigue
___ Nervousness
___ Loss of Weight
___ Numbness or pain in arms/legs/hands
___ Allergy (What)
___ Wheezing

GASTRO-INTESTINAL
___ Poor Appetite
___ Intestinal Cancer
___ Poor Digestion
___ Starvation
___ Belching or Gas
___ Nausea
___ Vomiting
___ Vomiting Blood
___ Pain over Stomach
___ Constipation
___ Diarrhea
___ Colon Trouble
___ Hemorrhoids
___ Fluid Retention
___ Liver Trouble
___ Gout
___ Jaundice
___ Gall - Bladder Trouble

MUSCLE & JOINTS
___ Weakness
___ Twitching
___ Stiff Neck
___ Backache
___ Swollen Joints
___ Tremors
___ Foot Trouble
___ Painful Tailbone
___ Pain Between Shoulders
___ Spinal Curvature

SKIN/ALLERGIES
___ Skin Cancer
___ Skin Eruptions
___ Itching
___ Bruising Easily
___ Dryness
___ Boils
___ Sensitive Skin
___ Hives or Allergies
___ Eczema

GENITO-URINARY
___ Frequent Urination
___ Painful Urination
___ Blood in Urine
___ Kidney Infection
___ Bed Wetting
___ Inability to control Urine
___ Prostate Enlargement
___ Prostate Cancer

CARDIO VASCULAR
___ Rapid Heart
___ Slow Heart
___ High Cholesterol
___ High Blood Pressure
___ Low Blood Pressure
___ Pain Over Heart
___ Heart Trouble
___ Swelling Ankles
___ Poor Circulation
___ Varicose Veins
___ Stroke
___ Palpitations

EYE/EAR/NOSE/THROAT
___ Poor Vision
___ Crossed Eyes
___ Pain in Eyes
___ Deafness
___ Earache
___ Ear Noises
___ Ear Discharges
___ Nasal Obstruction
___ Nose Bleeds
___ Sore Throats
___ Hoarseness
___ Hay Fever
___ Asthma
___ Frequent Colds
___ Enlarged Thyroid
___ Tonsillitis
___ Sinus Trouble

FOR WOMEN ONLY
___ Painful Periods
___ Excessive Flow
___ Irregular Cycle
___ Hot Flashes
___ Cramps or Backaches
___ Vaginal Discharge

Pleas List any other conditions that you have that are not listed.

_____

_____

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY (PMH):

Please list all past medical history including Heart, Lung, Kidney problems and medical problems such as diabetes, cancer, high blood pressure, pregnancy, etc.: _____

_____

_____

_____

Injuries/ Surgeries you have had:	Description	Date
Falls	_____	_____
Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications:	**Allergies:**	**Vitamins/ Herbs/ Minerals:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY (SH):

Marital Status: Married / Single / Divorced / Widowed

How many children do you have? _____ List any problems they have: _____

_____

Have you ever or do you smoke? **YES** **NO** How long? _____ Packs/ Day _____

Do you drink Alcohol? **YES** **NO** How much? _____ Drinks/ Wk/ Day _____

Do you drink coffee/ caffeine drinks? **YES** **NO** Cups/ Day _____

Do you have a high stress level? **YES** **NO** Why? _____

Exercise level: none moderate daily **(CIRCLE ANSWER)**

Work activity: Sitting Standing Light Labor Heavy Labor (**CIRCLE ANSWER)**

FEMALE ONLY:

Are you pregnant? **YES** **NO** Due Date: _____

First day of last menses? _____ Are your cycles regular? **YES** **NO**

FAMILY HISTORY (FH):

Is your mother alive? **YES** **NO** Major health problems: _____

Is your father alive? **YES** **NO** Major health problems: _____

How many brothers? _____ Sisters? _____ Major health problems: _____

Please list any other **Hereditary and/or Risk illnesses or diseases**: _____

_____

Patient Signature_____ **Date** _____

I certify that all my responses are complete and accurate.