



# Longmont Clinic

Name \_\_\_\_\_ Today's date \_\_\_\_\_

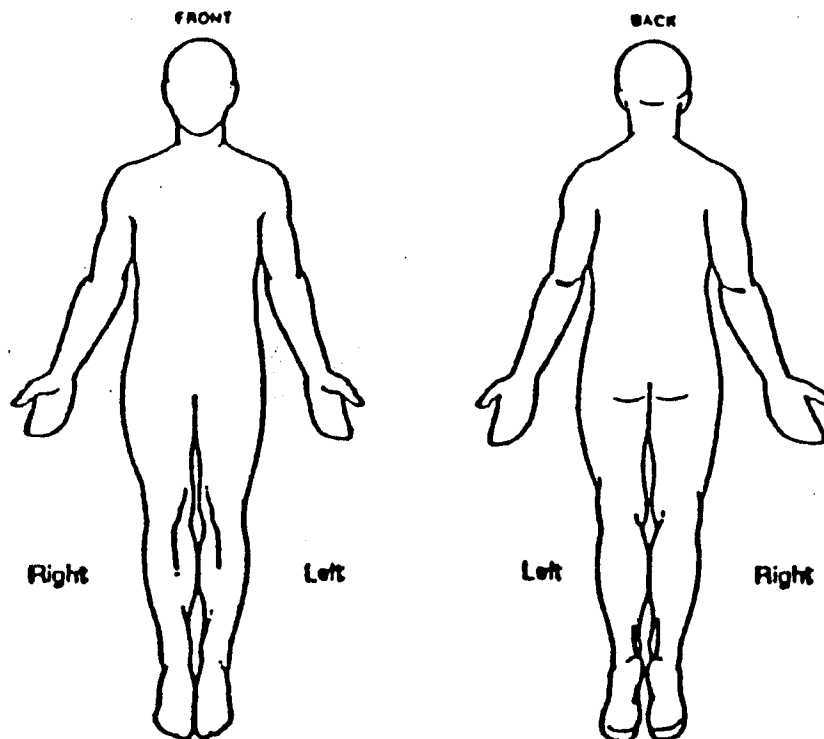
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Referred by \_\_\_\_\_

Legal Guardian \_\_\_\_\_

Present Complaint: \_\_\_\_\_

Date of Injury \_\_\_\_\_ When did symptoms first occur? \_\_\_\_\_

**IF YOU ARE EXPERIENCING ANY PAIN, PLEASE MARK THE LOCATION OF YOUR PAIN BASED ON THE DIAGRAMS BELOW.**



## **MEDICAL HISTORY:**

Past Illnesses \_\_\_\_\_

Conditions currently being treated \_\_\_\_\_

Do you have any continuing disabilities? If yes, please list: \_\_\_\_\_

**\*\*\* PLEASE COMPLETE OTHER SIDE \*\*\***

**GENERAL** (Please check any of the following symptoms, complaints or problems you have had recently or in the past year)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> headaches   | <input type="checkbox"/> chest pain              | <input type="checkbox"/> liver disease   |
| <input type="checkbox"/> dizzy spells  | <input type="checkbox"/> food intolerance        | <input type="checkbox"/> burning on urination  |
| <input type="checkbox"/> spots in front of eyes                              | <input type="checkbox"/> weight change           | <input type="checkbox"/> loss of sensation when urinating or having a bowel movement |
| <input type="checkbox"/> blurring of vision                                  | <input type="checkbox"/> nausea                  | <input type="checkbox"/> pain on urination   |
| <input type="checkbox"/> hearing problems                                    | <input type="checkbox"/> vomiting                | <input type="checkbox"/> poor bladder or bowel control                               |
| <input type="checkbox"/> shortness of breath                                 | <input type="checkbox"/> indigestion             | <input type="checkbox"/> tremors of extremities                                      |
| <input type="checkbox"/> cough   | <input type="checkbox"/> constipation            | <input type="checkbox"/> numbness or tingling of hands or feet                       |
| <input type="checkbox"/> unusual discharge or bleeding from ears and/or nose | <input type="checkbox"/> diarrhea                | <input type="checkbox"/> weakness that seems to be getting worse                     |
| <input type="checkbox"/> spitting up blood in sputum                         | <input type="checkbox"/> blood in stool or black | <input type="checkbox"/> convulsions   |
|  | <input type="checkbox"/> hemorrhoids             | <input type="checkbox"/> blacking out spells   |
|  | <input type="checkbox"/> ulcer                   |  |
|  | <input type="checkbox"/> none of the above       |  |

**SURGERIES** (Please provide procedure, date, place, physician). Also please list past injuries/broken bones.

_____	_____
_____	_____
_____	_____

**ALLERGIES & DRUG REACTIONS**

**MEDICATIONS** (Include NON PRESCRIPTION MEDICATION)  
(DOSAGE)

_____	_____
_____	_____
_____	_____

**FAMILY HISTORY**

Mother: Living \_\_\_\_\_ Age at death \_\_\_\_\_ Cause of death \_\_\_\_\_  
Father: Living \_\_\_\_\_ Age at death \_\_\_\_\_ Cause of death \_\_\_\_\_

Family Illnesses (Such as Diabetes, Cancer, Heart Disease, etc.)

**SOCIAL HISTORY**

Smoking \_\_\_\_\_ Drinking \_\_\_\_\_

Hobbies/Sports/Interests: \_\_\_\_\_

Marital Status \_\_\_\_\_ Children \_\_\_\_\_

Occupation \_\_\_\_\_