1296 S Shasta Ave
Eagle Point, OR 97524

3132 State St.
Medford, OR 97504

(Ph) 541.830.4325
(Fx) 541.826.2620
www.CompleteCare.net

(Please Print) **(Maiden Name if different)**

Name: ______________________ Date of Birth: ____________ Age: ________

Maritial Status: ______________________ Biological Gender: ________ Preferred Pronoun: ________

Address: ______________________ City, State, Zip: ______________________

Parent/Guardian: ______________________ Parent/Guardian Phone: ______________________

Cell/Home: ____________ Work Phone: ____________ Email: ______________________

Referral: GP / Ortho / Self / Other ____________ Due to: Work injury Y / N, Auto accident Y / N
Other ______________________

Previous PT: ______________________ Chiropractic: ______________________

Recent illness/accident: ______________________ Imaging: x-ray / MRI / Other ____________

Recent surgeries: ______________________

Tobacco: Y / N ______pack/day, ______years Alcohol: ______drinks/week Coffee: Y / N Soda/Energy: Y / N

Job: ______________________ Recreation: ______________________

% Time: _____standing, _____sitting, _____moving Days per week: ______________________

SYMPTOM HISTORY

Symptoms at Onset: ______________________

____

Present since (date): ______________________

Present symptoms: ______________________

____

Are symptoms: Improving / Unchanging / Worsening

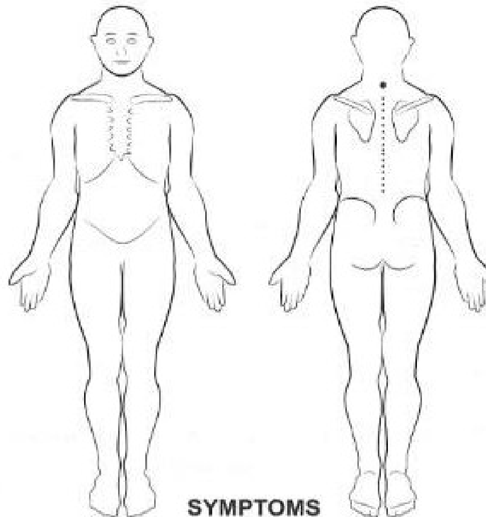
Are symptoms worse at any time of the day: Yes / No

If yes, when: ______________________

Previous episodes: 0 1-5 6-10 11+

Disturbed sleep: Yes / No Bed: firm / soft / sagging

Sleeping position: back / stomach / R side / L side



oooo Numb
. . . . . Tingling
- - - - Dull ache
xxxx Moderate pain
**** Severe pain

Aggravates your symptoms: ___at rest ___sitting ___standing ___twisting ___walking
___sneezing/coughing ___working ___lifting ___when moving ___when still ___intercourse

other: ______________________

Relieves your symptoms: ___at rest ___sitting ___standing ___lying down ___walking
___massage ___traction ___heat / ice ___am / pm ___when moving ___when still ___medications

other: ______________________

Women Only: ___Pregnant ___Breast implants ___Hysterectomy ___Birth Control ___Hormone Therapy

____

Printed Name of Patient of Authorized Representative

______________________ ____________

Signature of Patient of Authorized Representative Date

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QUADRUPLE VISUAL ANALOGUE SCALE & TIME %

Instructions: (please circle the appropriate number) 0 = no pain/symptoms, 10 = worst possible pain/symptoms

Your level of discomfort RIGHT NOW?	0	1	2	3	4	5	6	7	8	9	10
Your TYPICAL or AVERAGE level of discomfort?	0	1	2	3	4	5	6	7	8	9	10
Your level of discomfort AT ITS BEST?	0	1	2	3	4	5	6	7	8	9	10
Your level of discomfort AT ITS WORST?	0	1	2	3	4	5	6	7	8	9	10
What percentage of the time are you in pain?	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

FAMILY MEDICAL HISTORY

	Age at Death	Age if Alive	General Health; Major Health Issues;
Mother:	___________	___________	________________________________
Father:	___________	___________	________________________________
Sibling:	___________	___________	________________________________
Sibling:	___________	___________	________________________________

Family History of Any of the Below Conditions (check all that apply)

____Osteoporosis	____Diabetes	____Alcoholism	____Blood Clots
____Heart Attack	____Stroke	____Cancer	____TB
____Thyroid Disease	____Ulcers	____Mental Illness	____High Blood Pressure

PERSONAL MEDICAL HISTORY

(“P” = previous, “C” = current)

CONSTITUTIONAL
- P C Fatigue
- P C Weight Gain / Loss
- P C Fever

CARDIOVASCULAR
- P C High or low blood pressure
- P C Shortness of breath
- P C Heart disease
- P C Chest pain or angina pectoris
- P C Palpitations
- P C Feet or ankle swelling

GENITOURNIRAY
- P C Burning or painful urination
- P C Kidney stones
- P C Male: Erectile Dysfunction
- P C Male: Prostate problems

GASTROINTESTINAL
- P C IBS
- P C Abdominal Pain
- P C Nausea or vomiting
- P C Heartburn
- P C Stomach pain
- P C Constipation
- P C Diarrhea

RESPIRATORY
- P C Chronic or frequent cough
- P C Shortness of breath
- P C Asthma
- P C COPD

OTHER
- P C Diabetes
- P C Acne

MUSCULOSKELETAL
- P C Carpal Tunnel Syndrome
- P C Sciatica
- P C Fibromyalgia
- P C Difficulty walking
- P C Muscle pain or cramps
- P C Chronic Fatigue Syndrome

NEUROLOGICAL
- P C Peripheral neuropathy
- P C Freq./recurring headaches
- P C Convulsions or seizures
- P C Tremors
- P C Neurological Disorders
- P C Vertigo/dizziness
- P C Head injury/concussions
- P C Stroke
- P C Poor balance
- P C TIA’s – Mini-strokes

____
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Signature of Patient of Authorized Representative Date

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CURRENT MEDICATIONS & SUPPLEMENTS

Allergies: ______________________ Statins (Yes / No): ______________________

Any antibiotics within the last 2 months?: Yes / No Levaquin or Cipro?: Yes / No

Medication	Drug Dose	How Often

ADDITIONAL HOSPITALIZATIONS FOR SURGERY OR MAJOR ILLNESS

(not listed on front page)

Date	Operation/Hospitalization	Complications

ADDITIONAL SEVERE ACCIDENTS

(not listed on front page)

Date	Details

____

Printed Name of Patient of Authorized Representative

______________________________ ______________

Signature of Patient of Authorized Representative Date