General Health Screen – IncreaseYourV, LLC

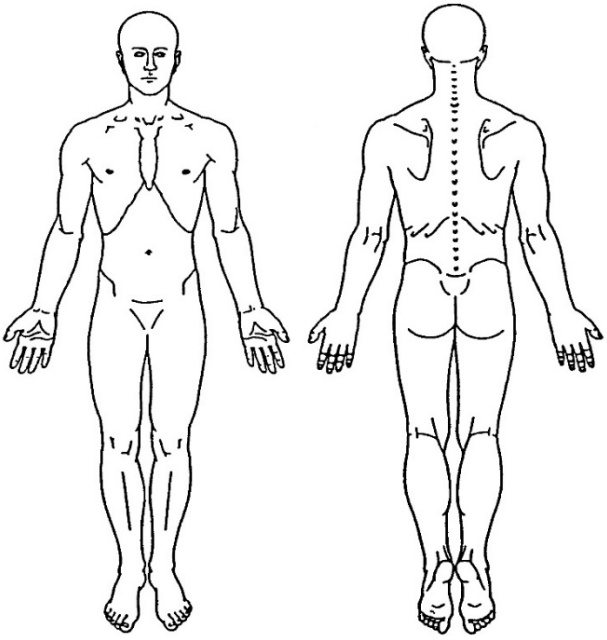
Today's Date: _____ **Name:** _____ **Date of Birth:** _____
Address: _____
Phone Number: _____ **Email:** _____
Age:_____ **Gender Identity:**_____ **Occupation:** _____
Insurance ID Number: _____ **PCP:** _____
PCP Clinic/Address: _____
Recreation/Hobbies/Sports: _____

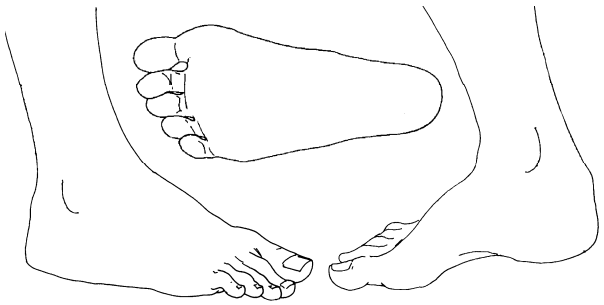
CURRENT SYMPTOMS:
Where are you currently having symptoms? _____
What date (roughly) did your present pain start? _____
Did your pain start: ☐Gradually? ☐Suddenly? ☐By Injury? Explain: _____
Have you ever had this problem before?: ☐Yes ☐No If yes, when: _____
Have you received treatment for this problem before?: ☐Yes ☐No If yes, when: _____
What aggravates your pain? ☐Sitting ☐Rise from Sit ☐Standing ☐Lying Down ☐Overhead Activity
☐Lifting ☐Bending ☐Push-Ups ☐Sit-Ups ☐Walking ☐Running ☐Stairs ☐Squatting ☐Kneeling
☐Jumping/Side Straddle Hop ☐Getting Dressed ☐Cough/Sneeze ☐When Upset
☐Other: _____
What eases your pain? ☐Ice ☐Heat ☐Rest ☐Elevation ☐Changing Positions ☐Other: _____

	No Pain			Pain Scale (please place X in appropriate box)						Maximum Pain
	0	1	2	3	4	5	6	7	8	9	10
Pain today?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maximum - past several days	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Minimum – past several days	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please draw in your primary complain using the diagram and the markings (also draw other pain areas that you may have at this time)

Ache	Burning	Numbness	Pins and Needles	Throbbing	Other/General Pain
^^^^^	=======	oooooooooo	……	//////////////////	xxxxxxxxxxxxxxxxxx
^^^^^	======	oooooooooo	……	//////////////////	xxxxxxxxxxxxxxxxxx





My goal for therapy is: _____

General Health Screen

Circle YES or NO…

Have you or any immediate family member ever been told you have: ..... ***Self*** ***Family***

	Self	Family
Cancer ?	Yes ☐ No ☐	Yes ☐ No ☐
Diabetes ?	Yes ☐ No ☐	Yes ☐ No ☐
High blood pressure ?	Yes ☐ No ☐	Yes ☐ No ☐
Heart disease ?	Yes ☐ No ☐	Yes ☐ No ☐
Angina/chest pain ?	Yes ☐ No ☐	Yes ☐ No ☐
Stroke ?	Yes ☐ No ☐	Yes ☐ No ☐
Osteoporosis ?	Yes ☐ No ☐	Yes ☐ No ☐
Osteoarthritis ?	Yes ☐ No ☐	Yes ☐ No ☐
Rheumatoid arthritis ?	Yes ☐ No ☐	Yes ☐ No ☐

In the past 3 months have you had or do you experience:

- A change in <u>your</u> health ? ..... Yes ☐ No ☐
- Nausea/Vomiting ? ..... Yes ☐ No ☐
- Fever/chills/sweats ? ..... Yes ☐ No ☐
- Unexplained weight change ? ..... Yes ☐ No ☐
- Numbness or tingling ? ..... Yes ☐ No ☐
- Changes in appetite ? ..... Yes ☐ No ☐
- Difficulty swallowing ? ..... Yes ☐ No ☐
- Changes in bowel or bladder function ? .. Yes ☐ No ☐
- Shortness of breath ? ..... Yes ☐ No ☐
- Dizziness ? ..... Yes ☐ No ☐
- Upper respiratory infection ? ..... Yes ☐ No ☐
- Urinary tract infection ? ..... Yes ☐ No ☐
- Change in your balance (⇑ falls)……. Yes ☐ No ☐
- Vision changes/double vision ..... Yes ☐ No ☐

Do you or have you in the past smoked tobacco?

YES☐ NO☐

If yes, _____Packs/day **X** _____Years.

Last tobacco use _____

Do you drink alcoholic beverages? YES☐ NO☐

If yes, how many drinks do you routinely have per week? _____/week.

Date of last physical examination _____

Circle YES or NO…

Do you have a history of:

- Allergies/Asthma ? ..... Yes ☐ No ☐
- Headaches ? ..... Yes ☐ No ☐
- Bronchitis ? ..... Yes ☐ No ☐
- Kidney disease ? ..... Yes ☐ No ☐
- Rheumatic fever ? ..... Yes ☐ No ☐
- Ulcers ? ..... Yes ☐ No ☐
- Sexually transmitted disease ? ..... Yes ☐ No ☐
- Seizures ? ..... Yes ☐ No ☐

Are you currently:

- Pregnant ? ..... Yes ☐ ..... No ☐
- Depressed ? ..... Yes ☐ ..... No ☐
- Under Stress ? ..... Yes ☐ ..... No ☐

During the past month have you been feeling down, depressed or hopeless? ..... Yes ☐ ..... No ☐

During the past month have you been bothered by having little interest or pleasure in doing things? Yes ☐ ..... No ☐

Is feeling down, depressed or hopeless something which you would like help with?

- Yes Help today ..... ☐
- Yes Help, but not today ..... ☐

Are your symptoms: (check one)

☐ Getting worse ☐ The same ☐ Improving

How are you able to sleep at night? (check one)

☐ Fine ☐ Moderate difficulty ☐ Only with medication

Do you have a problem with ... (check all that apply)

☐ Hearing ☐ Vision

☐ Speech ☐ Communication

My symptoms are worse in the:

☐ Morning ☐ Afternoon ☐ Evening ☐ Night

My symptoms are best in the:

☐ Morning ☐ Afternoon ☐ Evening ☐ Night

List medications currently using:

_____

_____

Patient's Signature: _____