THE THAMES CLINIC CONFIDENTIAL HISTORY

Primary Complaint: _____ Onset: _____

Intensity of Pain (please circle): 0=none 1-3=mild 4-6=moderate to severe 7-9=very severe 10=intolerable

Secondary Complaint: _____ Onset: _____

Intensity of Pain (please circle): 0=none 1-3=mild 4-6=moderate to severe 7-9=very severe 10=intolerable

Any Other Complaint: _____ Onset: _____

Intensity of Pain (please circle): 0=none 1-3=mild 4-6=moderate to severe 7-9=very severe 10=intolerable

The pain is worse in the: [ ] am [ ] midday [ ] pm

Describe the character of the pain (e.g. sharp, dull, etc.): _____

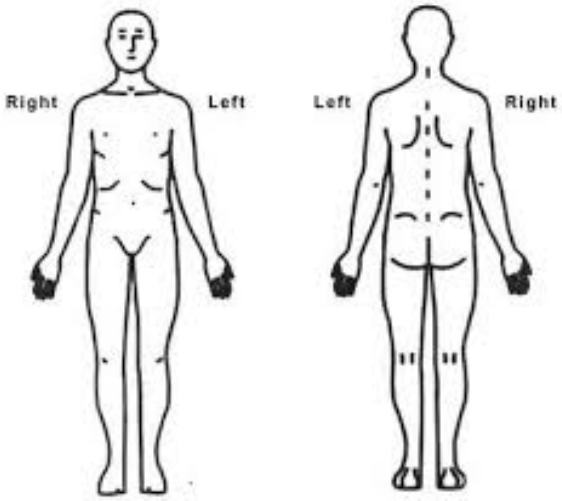
The pain is getting: [ ] better with time [ ] worse with time [ ] the same with time

The pain is: [ ] constant [ ] come and goes

Is the pain spreading? Y / N If yes, where: _____

Suffer from headaches? Y/ N If yes, for how long: _____

Please mark the areas affected on the diagram:



What relieves your symptoms: _____

What aggravates your symptoms: _____

The pain interferes with: [ ] home [ ] work [ ] leisure

Has your condition been treated in the past: Y / N When and by whom: _____

Your expectations for treatment: [ ] pain relief [ ] spine/posture correction [ ] optimize health

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List any injuries/traumas/accidents/fractures:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

List any surgeries and hospitalizations:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

List any medication:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Family medical history: _____

Please rate your stress level (0=no stress 10=extreme stress): 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10

Do you sleep on your: [ ] Back [ ] Side [ ] Stomach Number of pillows: _____

How many hours do you sleep each night: _____ If less than 7 hours, why: _____

Physical activities or sports: Y / N
If yes, which activities/sports: _____

How much water do you drink/day: _____ How many cups of tea or coffee/day: _____

Do you smoke: Y / N If yes, how many cigarettes/ day: _____

Do you drink alcohol: Y / N If yes, how many units/week: _____

FOR WOMEN: Is there any possibility that you might be pregnant: Y / N If yes, weeks: _____

Please check off any physical ailments you are experiencing/have experienced in the past:

Checkboxes

[ ] cancer	[ ] night pain/sweats	[ ] high blood pressure	[ ] heart attack
[ ] high cholesterol	[ ] stroke	[ ] heartburn	[ ] breathing difficulties
[ ] asthma	[ ] diabetes	[ ] fatigue	[ ] anxiety
[ ] depression	[ ] tremors	[ ] ringing in the ears	[ ] hearing loss
[ ] dizziness/vertigo	[ ] osteoporosis	[ ] arthritis	[ ] sleeping disorders
[ ] joint stiffness	[ ] scoliosis	[ ] digestive disorders	[ ] weight gain/loss
[ ] vision disorders	[ ] skin problems	[ ] urinary disorders	[ ] fever/chills
[ ] sexual dysfunction	[ ] epilepsy	[ ] ear infections	[ ] loss smell/taste
[ ] allergies	[ ] thyroid disorder	[ ] prostate disorder	[ ] sinus problems
[ ] frequent cold/flu	[ ] eating disorder		

[ ] other:_____

I, _____ declare that I have provided all the information requested to the best of my knowledge, and now consent to a physical examination.

Signature: _____ Date: _____