Won S. Yoo, D.C.

s

Specializing in Spine & Joint Disorders · Injurie

Oakland Clinic 281 13th Street, Oakland, CA 94612 Tel. 510.465.8707 Fax. 510.465.8660
San Francisco Clinic 1489 Webster Street, #202, San Francisco, CA 94115 Tel. 415.931.3569 Fax. 415.931.3655
www.drwonyoo.com

PLEASE TAKE A FEW MINUTES TO FILL OUT THIS FORM.
CLINIC LOCATION: ☐ **OAKLAND** ☐ **SAN FRANCISCO**

NAME: _____ HOME PHONE: ( ) ____-_____ WORK PHONE: ( ) ____-_____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
E-MAIL ADDRESS: _____@_____
SOCIAL SECURITY #: _____-___-_____ BIRTH DATE: ___/___/_____ AGE: ____ SEX: ☐ MALE ☐ FEMALE
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED
YOUR INSURANCE CO.: _____ POLICY#: _____
OCCUPATION: _____ EMPLOYER'S NAME & PHONE: _____
EMPLOYER'S ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

CHIEF COMPLAINTS:

_____

_____

Date and cause of initial onset: _____
Date and cause of recent exacerbation: _____
Duration: _____
Character (dull/sharp, radiating/local, deep/superficial, etc.): _____
Intensity (slight, minimal, moderate, severe, etc.): _____
Provokes/aggravates: _____
Ameliorates: _____

CASE HISTORY:

Please mark any conditions or symptoms that you have had in the **Past (P)** or **Currently (C)** experiencing.

GENERAL HISTORY

P	C		P	C		P	C	
☐	☐	Trauma/Injury	☐	☐	Height change	☐	☐	Weight change
☐	☐	Fever/chills	☐	☐	HIV positive	☐	☐	Allergies
☐	☐	Anemia	☐	☐	Bleeding/bruising	☐	☐	Malaise/fatigue/weakness

FAMILY HISTORY

P	C		P	C		P	C	
☐	☐	Diabetes	☐	☐	Thyroid	☐	☐	Tuberculosis
☐	☐	Kidney disease	☐	☐	High blood pressure	☐	☐	Heart disease/stroke
☐	☐	Cancer	☐	☐	Other	☐	☐	Musculoskeletal disease

ENDOCRINE SYSTEM

P	C		P	C		P	C	
☐	☐	Diabetes	☐	☐	Thyroid problems	☐	☐	Hot/cold intolerance
☐	☐	Neck surgery	☐	☐	Neck irradiation	☐	☐	Other

EYE/EAR/NOSE/THROAT

P	C		P	C		P	C	
☐	☐	Visual problems	☐	☐	Eye irritation	☐	☐	Pain in eyes
☐	☐	Ear pain	☐	☐	Difficult hearing/deaf	☐	☐	Ringing in ears/dizziness
☐	☐	Nosebleeds	☐	☐	Sneezing	☐	☐	Chang in ability to smell
☐	☐	Nose pain	☐	☐	Sinusitis	☐	☐	Other nose problems
☐	☐	Hoarseness	☐	☐	Change in voice	☐	☐	Difficult swallowing
☐	☐	Enlarged glands	☐	☐	Change in taste	☐	☐	Growths in mouth/throat
☐	☐	Dental problems	☐	☐	Other			

RESPIRATORY SYSTEM

P	C		P	C		P	C	
☐	☐	Difficult breathing	☐	☐	Cough	☐	☐	Blood in sputum
☐	☐	Wheezing/asthma	☐	☐	Pneumonia	☐	☐	Tuberculosis/exposure
☐	☐	Smoking history	☐	☐	Daily_____	☐	☐	Years_____

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Patient's Name: _____ **Date:**_____

GASTROINTESTINAL SYSTEM

P	C		P	C		P	C	
☐	☐	Change in appetite	☐	☐	Food intolerance	☐	☐	Nausea/vomiting
☐	☐	Vomiting of blood	☐	☐	Indigestion/heartburn	☐	☐	Abdominal swelling
☐	☐	Abdominal pain	☐	☐	Peptic ulcer	☐	☐	Change in stool/color/etc.
☐	☐	Diarrhea	☐	☐	Gas	☐	☐	Hernia
☐	☐	Hemorrhoids	☐	☐	Gallbladder disease	☐	☐	Liver disease
☐	☐	Pancreatitis	☐	☐	Alcohol intake_____			

CARDIOVASCULAR SYSTEM

P	C		P	C		P	C	
☐	☐	Palpatations	☐	☐	Edema/swelling	☐	☐	Fainting
☐	☐	High blood pressure	☐	☐	Past heart disease	☐	☐	Rheumatic fever
☐	☐	Shortness of breath with exercise_____						
☐	☐	Chest discomfort/pain Type_____ How often_____						

URINARY SYSTEM

P	C		P	C		P	C	
☐	☐	Pain on urination	☐	☐	Change in color	☐	☐	Difficulty in starting stream
☐	☐	Discharge	☐	☐	Urinary tract infection	☐	☐	Difficulty in holding stream
☐	☐	Kidney disease	☐	☐	Flank pain	☐	☐	Pelvic pain

Frequent urination: # times day_____ # times night_____

BREASTS

P	C		P	C		P	C	
☐	☐	Bumps/lumps/mass	☐	☐	Dimples in breast	☐	☐	Change in color/shape
☐	☐	Nipple discharge	☐	☐	Other _____			

NEUOLOGICAL SYSTEM

P	C		P	C		P	C	
☐	☐	Headaches	☐	☐	Epileptic seizure	☐	☐	Tics/spasm
☐	☐	Dizziness/fainting	☐	☐	Unusual weakness	☐	☐	Disturbances of sensation
☐	☐	Head trauma	☐	☐	Stroke	☐	☐	Other

MUSCULOSKELETAL SYSTEM

P	C		P	C		P	C	
☐	☐	Joint stiffness	☐	☐	Decrease motion	☐	☐	Joint pain
☐	☐	Joint swelling	☐	☐	Muscle cramps	☐	☐	Muscle weakness
☐	☐	Muscle wasting	☐	☐	Neck pain	☐	☐	Mid back pain
☐	☐	Low back pain	☐	☐	Sacroiliac pain	☐	☐	Tailbone pain
☐	☐	Arm problems	☐	☐	Leg problems	☐	☐	Fractures/dislocations
☐	☐	Sprain/strains	☐	☐	Other injuries	☐	☐	Other problems

HOSPITALIZATIONS AND MEDICATIONS

P	C	
☐	☐	Hospitalizations_____
☐	☐	Medications_____

DIET AND VITAMINS

P	C		P	C		P	C	
☐	☐	Eat sporadically	☐	☐	Skip breakfast	☐	☐	Eat between meals
☐	☐	Eat late at night	☐	☐	Eat junk food	☐	☐	Special diet
☐	☐	Vegetarian	☐	☐	Supplements_____			

IMPLANTS

P	C		P	C		P	C	
☐	☐	Breast implants	☐	☐	Cardiac pacemaker	☐	☐	Other

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Patient's Name: _____ **Date:**_____

FEMALE PATIENTS

Menarche (1st period) Age_____
Menstrual flow ☐Scant ☐Light ☐Moderate ☐Heavy
Menstrual regularity Days in cycle_____ Duration/days_____
Menstrual cramping Pain 0 1 2 3 4 5
PMS Pain 0 1 2 3 4 5
First day of last cycle_____ Date of last PAP test_____
Menopause onset_____ Postmenopausal bleeding_____
Other female problems_____ Hysterectomy_____
Birth control method_____

VISUAL ANALOG PAIN SEVERITY SCALE

Please Mark your pain level at the present time.

No Pain ⊙ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ **Worst Possible Pain**

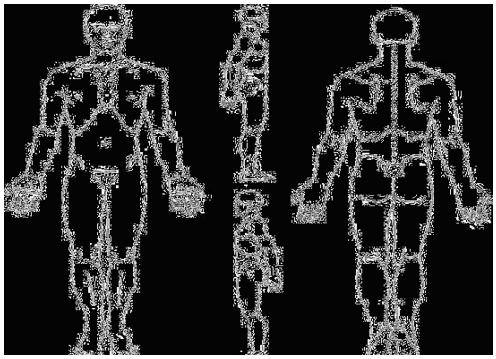
0 1 2 3 4 5 6 7 8 9 10

Pain Level	Intensity Level	Disability	Restrictions
0	None	None	None
1	Minimal	Minimal handicap in the performance of any activity causing the pain. Able to perform all normal activities of daily living without significant pain. At the low end of "minimal," the pain is viewed as just an annoyance.	Can do all the normal activities without restriction, even though pain is present.
2 – 3	Slight	Slight handicap in the performance of any activity causing the pain. Able to perform all normal activities of daily living without significant pain. At the low end of "minimal," the pain is viewed as just an annoyance.	Can do all the normal activities without restriction, even though pain is present.
4 - 7	Moderate	There is marked handicap in the performance of any activity causing the pain. Some activities of daily living area typically performed more slowly, for a shorter duration, and/or there is the need for more frequent breaks. These activities may be minimized when possible so as to limit the pain.	Certain activities are difficult to perform and may require modifying the duration and intensity at which they are done.
8 - 10	Severe	Unable to do the activities that cause the pain. If the activity that causes the pain is attempted, flare-ups of the condition are likely. Avoidance of such activities is mandatory at this level of disability.	Major modifications in work and/or home activities are typically present.

Indicate the pain location and the type of pain that you are currently experiencing

Numbness ===== **Aching** aaaaa **Burning** xxxxx **Stabbing** / / / / /

Pins and needles ooooo **Other** _____



I certify that the above information is true and correct to the best of my knowledge.

Patient's Signature: _____ **Date:** _____