Body in Harmony, PC
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Dr. Marcella Ziska

Dr. Danielle Clear

Current History

Date:_____ Patient Name:_____ Case #:_____

What is your chief complaint?_____

What is the location of your chief complaint?_____

If you have pain, does it travel and to where?_____

When did this issue begin? Date of Onset:_____

What specific event brought it on?_____

Was its onset Sudden or Gradual? (please circle one)

Have you had anything like this before the above date? Dates/Event :_____

Since your symptoms started, have they Increased, Decreased or Stayed the Same? (please circle one if it applies)

Severity: Mild (0,1,2,3) Moderate(4,5,6) Severe (7,8,9,10)

(please put a number in each blank): Min: _____ Max:_____ Now: _____

Please describe your pain: Sharp, Dull, Burning, Ache, Throb, Tingling, or Other words you would use_____

Time: Does the pain occur all the time_____ or does it come and go_____?: (Check one)

Is the pain: **Better, Worse** in the **AM** compared to **Better, Worse** in the **PM**: or about the **Same** throughout the day? (circle appropriate choice)

If you have pain how long does it last when it occurs?:_____

What makes it better?:_____

What makes it worse?:_____

What other Doctors/Health Care Professionals have you seen for this problem?

_____

List medication you take for this condition:_____

List other medication/supplements you are currently taking:_____

_____

Last Physical Exam Date:_____ Blood Pressure History: high, low or normal (circle one)

Have you ever suffered from

o Alcoholism	o Chest Pain/Conditions	oFrequent Urination	o Loss of Balance	o Swollen Joints
o Allergies	o Cold Extremities	o Headache	o Loss of taste	o Tuberculosis
o Anemia	o Constipation Cramps	o Hemorrhoids	o Neck Pain or Stiffness	o Ulcers
o Arteriosclerosis	o Depression	o High Blood Pressure	o Nervousness	o Varicose Veins
o Arthritis	o Diabetes	o Hot Flashes	o Pacemaker	o Venereal Disease
o Asthma	o Digestion Problems	o Irregular Heart Be	o Polio	o Others _____
o Back Pain	o Dizziness	o Irregular Cycle	o Poor Posture	_____
o Breast Lump	o Ear Ringing	o Kidney Infection	o Prostate Trouble	_____
o Bronchitis	o Excessive Menstruation	o Kidney Stones	o Sciatica	_____
o Bruise Easily	o Eye Pain/Difficulties	o Loss of Memory	o Shortness of Breath	_____

Hospitalizations/Surgeries:_____

_____

Accidents (Falls/Auto)_____

_____

Work Hours:_____/Wk Sleep Hours:_____/Night Exercise Hours:_____ /Wk

Type of Exercise:_____

Family Health History (Illnesses, Medications, Deaths)

Mom and her family:_____

Dad and his family:_____

Siblings:_____

Describe what you typically eat for: Brkfst_____ Lunch_____
Supper_____ Snacks_____

What is your intake per day of: Caffeine _____Tobacco _____ H20 oz. _____ Alcohol_____

Dr. Signature:_____