Dr. Robert E. Monokian Date: _____

Pt Name: _____ File #: _____

REASON FOR VISIT

1. Main reason for consulting our office: (Primary Complaint)

2. Do you know the cause of your condition? Yes No
   If YES, describe the onset (How did it start): Gradual Sudden
   Date of Onset - When did you first notice the symptoms?

3. How did the injury occur? _____
   Was this condition a result of an accident? Yes No
   If YES, what type of accident? Automobile / at Work / Accident at Home / Sports Accident / or Other:
   Please describe accident briefly:

4. Is the problem: Getting Worse, Staying the Same, Improving

5. How was your health prior to this condition?
   Have you ever had this condition before? Yes No If YES, how many times before?

6. Regarding your AREA OF PRIMARY COMPLAINT – and your PAIN – please circle all that apply:
   HOW OFTEN: Constant / Frequent / Intermittent / Occasional
   SEVERITY: Mild / Mild to Moderate / Moderate / Moderately Severe / Severe / Very Severe
   TIME OF DAY: MORNING: Worse / Better DAY: Worse / Better NIGHT: Worse / Better
   MOVEMENT: Inflexibility / Restricted Movement / Stiffness
   SENSATIONS: Crawling / Dead / Numb / Pins and needles / Prickly / Tingling
   PAIN TYPES: Aching / Burning / Dull / Excruciating / Numb ache type / Pounding / Sharp / Shooting / Stabbing / Stinging / Throbbing
   AREA: Generalized in / Localized in / Migrating to / Radiating to / Shooting into _____
   AGGRAVATED BY: Coughing / Sneezing / Straining at BM's / Arising from a chair / Bending / Carrying / Climbing a ladder / Climbing stairs / Driving / Exercising / Getting out of bed / Getting in and out of the car / Lifting / Pulling / Pushing / Reclining / Repetitious movements / Sitting / Standing / Stooping / Walking uphill / Walking / Emotional upset / Stress
   RELIEVED BY: Having adjustments / Taking Advil / Aspirin / Pain pills / Tylenol / Exercising / Resting / Sitting / Sleeping / Walking / Cold / Massaging by hand / Heat / Rubbing heat liniment Hot showers / Mineral ice / Nothing / Tub soak / Massaging with vibrator / Stretching

   IF YOU HAVE A SECOND OR THIRD AREA OF COMPLAINT OR INVOLVEMENT -
   PLEASE ASK FOR AN ADDITIONAL SHEET TO DESCRIBE YOUR OTHER AREAS OF CONCERN.

7. Please circle any changes in your functional habits you have noticed: Appetite, Urination, Bowel movements, Menstrual cycle, or Other:

8. Have you missed work due to this condition? Yes No If YES, how much?

9. Has this condition interfered with any of the following? Sleep, Appetite, Energy level, Immune system, Recreation, Social life, or Other:

10. Have you seen another doctor or anyone else for this condition? Yes No
    If YES, Who and Where? _____
    Diagnosis: _____
    Lab tests: Urinalysis Blood Tests, or other: _____
    What advice or treatment did they provide? _____
    Length of time under care: _____ Results: _____
    May Dr. Monokian communicate with him/her about your case? Yes No If YES, please Initial here: _____

11. For this condition, did you have any films taken? Yes No
    If YES, were they: Xrays / CT Scan / MRI
    If YES, where are they?

Dr. Robert E. Monokian Date: _____

Pt Name: _____ File #: _____

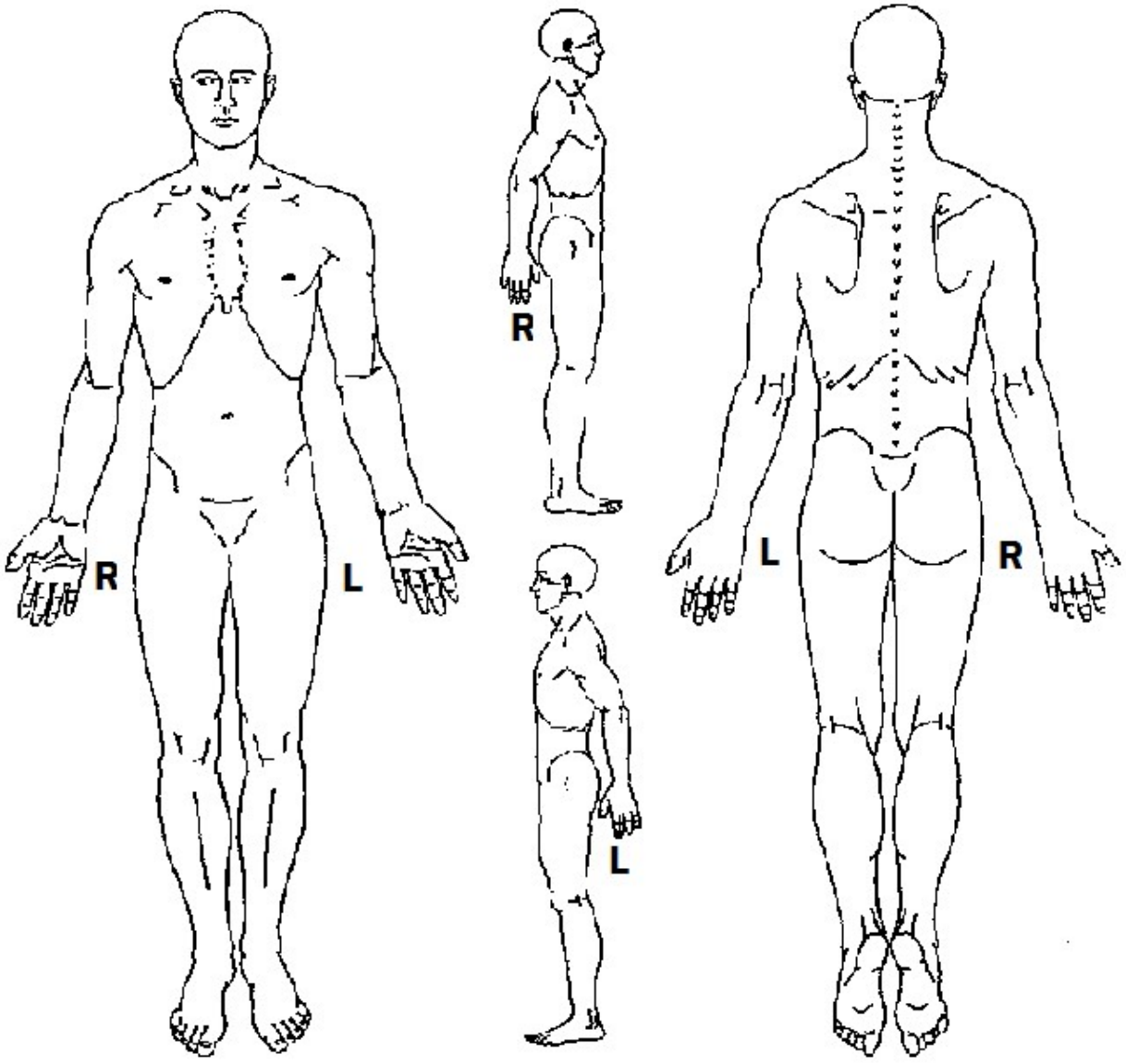
PAIN DRAWING

PAIN SCALE: On a scale of 1-10, please CIRCLE a number on the scale to indicate your level of pain:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN IMAGINABLE

Draw the following letters on the diagram below; indicating the LOCATION of your pain and the TYPE of pain sensations you are experiencing right now. If you have multiple areas of pain, you may also write the PAIN SCALE number (0 through 10) next to each area on the diagram.

A = Ache
B= Burning
N= Numbness
P= Pins and Needles
S= Stabbing
O= Other



Dr. Robert E. Monokian Date: _____

Pt Name: _____ File #: _____

DETAILED HEALTH HISTORY

We understand filing out forms can be tiresome; however, your health history gives the doctor over 80% of the information needed to make a diagnosis. Please take the time to be thorough with your responses. Use additional pages if you need more space for your answers. Feel free to attach copies of any reports or health records. Upon request, our office will gladly provide you with a copy of the completed form for your personal health records.

1. List all medications or drugs you are currently taking – include dosage and strength – and what they are used for: Use back of form if needed.

2. Please list any ALLERGIES you have:

3. List all medications you are allergic to and describe the reaction you experience:

4. Past Surgeries (Include dates):

5. Past Hospitalizations (Include dates):

6. Past Medical Treatment (Include dates):

7. Past Lab Results (ex. Blood Work, Bone Density, X-rays, CT or MRI) List the date of test and name the extremity viewed:

8. Have you ever been in a motor vehicle accident (fender-benders included)? Yes No
If yes, when and what injuries if any did you suffer?
Please explain any long-term effects.

9. Past history of Trauma or falls causing injury to your body (Include dates):

Page 2 - DETAILED HEALTH HISTORY

10. Have you ever been on any medication for an extended period of time (longer than 10 days)? Yes No
If yes, please explain:

11. How would you rate your general health? Bad, Poor, Fair, Good, Excellent

12. Do you smoke? Yes No If yes, how many a day?
If no, did you ever smoke? Yes No If yes, for how long? When did you quit?
Do you or have you ever used other tobacco products? Yes No If yes, please list.

13. Do you drink alcohol? Yes No If yes, how much and how often?

14. Do you drink caffeinated beverages? Coffee, Tea, Soft Drinks
How many a day?

15. Do you use any recreational drugs? Yes No If yes, please discuss with Dr. Monokian.
If no, Did you use recreational drugs in the past? Yes No

16. Do you exercise on a regular basis? Yes No
If yes, how many times (on average) a week? 1x 2x 3x 4x 5x 6x 7x
If yes, please circle all activities that you perform: Walk, Run, Bike, Stair step, Rowing _____
Aerobics, Pilates, Weight Training, Stretching Exercises, Pool swim, Ocean swim,
Others: _____
Do you exercise at: Home, Gym
Do you have physical hobbies? Please list.

17. How many glasses of water do you drink daily?

18. Do you eat a special Diet? Yes No If yes, please explain:

19. Do you take any vitamins / minerals / other nutritional supplements? Yes No
If yes, please list type and dosage. Use back of form if necessary.

Supplement:	How Much?	How Often?

20. Have you experienced any of the following in the past 12 months?
Personal Injury or illness, Major illness in family, Death in family, Death of a Spouse/Child,
Death of close friend, Job Change or Retirement, Divorce or Separation, Marriage,
Move/Change of Residence, Loss of Pet , Birth of Child, Financial Crisis, Natural Disaster Loss (Hurricane/Tornado/Flood)

21. WOMEN ONLY – are you currently:
Performing Monthly Breast Examinations? Yes No
Have you had mammography? Yes No Date of last study: _____
Experiencing abnormal vaginal or menstrual bleeding? Yes No Date of last menses: _____
Taking Birth Control Pills? Yes No
Taking Hormone Replacement Therapy / Estrogen Supplements? Yes No
Are you Pregnant? Yes No
Are you Nursing a child? Yes No
Do you feel safe in your home environment? Yes No

Dr. Robert E. Monokian Date: _____

Pt Name: _____ File #: _____

Page 3 - DETAILED HEALTH HISTORY

22. MEN ONLY – are you currently:
Performing monthly self-testicular exams? Yes No
Performing monthly self-breast exams? Yes No
Do you feel safe in your home environment? Yes No

23. HISTORY OF CONDITIONS: Have you ever had: (Check if yes)

___ Pain in your chest or heart
___ Heart attack
___ Stroke
___ Heart bypass surgery
___ Any heart problem of any kind
___ Heart murmur
___ Arteries or vein problems
___ Blood Transfusion
___ Abnormal EKG
___ Extra or skipped heart beats
___ Hernias
___ Aneurysm – Location:
___ Undiagnosed abnormal pain
___ Phlebitis
___ Asthma
___ Anemia
___ Diabetes
___ Epilepsy
___ Bronchitis or Asthma
___ Bleeding disorder
___ Pneumonia
___ Any lung disease
___ Emotional problems – nervous
___ Injuries to back, arms, legs
___ Back pain
___ Arthritis / Gout
___ Dizziness or fainting spells
___ Spinal surgery
___ Unusual swelling
___ Rheumatic Fever
___ Jaundice
___ Breathlessness on exertion
___ High blood pressure
___ High cholesterol
___ Cancer
___ Glaucoma
___ Pneumonia
___ Emphysema
___ Tuberculosis
___ Hepatitis
___ Venereal Disease
___ HIV / AIDS
___ Other infectious diseases _____
_____
_____

24. FAMILY HISTORY: Do any of your blood relatives have / had any of the following?
If possible, give ages when occurred and indicate if fatal.

	(M)other	(F)ather	Sibling (B)rother/ (S)ister	Grandmother	Grandfather
Heart attack			B / S	M / F	M / F
Stroke			B / S	M / F	M / F
High blood pressure			B / S	M / F	M / F
Elevated cholesterol			B / S	M / F	M / F
Diabetes			B / S	M / F	M / F
Obesity			B / S	M / F	M / F
Orthopedic Problems			B / S	M / F	M / F
Are they DECEASED?			B / S	M / F	M / F
Are they HEALTHY?			B / S	M / F	M / F
Other:					

25. When was your last medical physical exam? _____

Medical Doctor / Primary Care Physician Name: _____

Medical Doctor's Address: _____

_____

What conditions were you treated for? _____

_____

May Dr. Monokian contact/communicate with him/her about your case? Yes No
If yes, please Initial here: _____ If no, please give reason:

26. When was your last chiropractic visit? _____

Previous Chiropractor's Name: _____

Chiropractor's Address: _____

_____

What conditions were you treated for? _____

_____

May Dr. Monokian contact/communicate with him/her about your case? Yes No
If yes, please Initial here: _____ If no, please give reason:

27. How old is your bed mattress? _____

What position do you sleep in? On my: (Please circle) Side Back Stomach

28. In addition to treatment for the above described condition, are you seeking help for any of the following? (please check all that apply)

____ General Health
____ Wellness
____ Prevention & Wellness
____ Exercise Guidance
____ Nutritional Guidance
____ Weight Loss Guidance
____ Just to patch-fix the condition described, nothing more
____ Other: _____

Any other Comments?

Dr. Robert E. Monokian Date: _____

Pt Name: _____ File #: _____

CONFIDENTIAL PATIENT INFORMATION FORM

PLEASE PRINT:

Mr Ms Mrs Dr PATIENT NAME:
(First Middle Last)

What do you like to be called? (nickname)

Whom may we thank for referring you?

STX Mailing Address :

STX Physical Address:

Stateside Mailing Address: Stateside Phone:

Email Address _____
May Dr. Monokian communicate with you via email? **Yes** **No** If YES, please initial here: _____
Home Phone: Work Phone: Cell Phone:

CELL PHONE PROVIDER CIRCLE ONE: SPRINT/ AT&T/ VERIZON/ T-MOBILE

Sex: Male Female Age: Birth Date:

Your Employer: Your Occupation:

Your Employer Address: Your Employer Phone :

May we call you at work? **Yes** **No** If YES, please Initial here: _____
Work Email Address _____

Marital Status: Married Single Divorced Separated Widowed Student

Spouse's Name: _____

If you are a student or child – your parents names:

Spouse's Employer: Spouse's Occupation:

# of Children: _____ Names and Ages of Children:

Use spouse as EMERGENCY CONTACT **Yes** **No**

EMERGENCY CONTACT Name: _____ Phone Number: _____
NAME OF PERSON RESPONSIBLE FOR PAYMENT ON THIS ACCOUNT:

INSURANCE: Our office participates with the VI EQUICARE network of Insurance Carriers. If you would like us to consider your insurance for partial payment on your account, please complete the following:

Name of INSURANCE CARRIER: _____

Group Policy # _____ Subscriber ID/Certificate # _____

Name of Insured on card: _____ Date of Birth of Insured: _____

Patient Relationship to Insured: Self, Spouse, Child Other: _____

PLEASE GIVE YOUR INS CARD TO THE FRONT DESK so that we may make a photocopy of it for our records.