PATIENT HISTORY

Please PRINT and fill out completely

Name: ____________________ Today's Date: ____________________

Age: ________ Height: ________ Weight: ________ Hand Dominance: ☐ Left ☐ Right

Occupation: ____________________

History of Present Injury (Why are you here today?)

Injury to: ☐ Left ☐ Right ☐ Both
Arm ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand
Leg ☐ Upper leg ☐ Knee ☐ Lower leg ☐ Ankle ☐ Foot
Other: ____________________

Did your problems result from a specific injury? ☐ Yes ☐ No Injury/Accident Date (mm/dd/yyyy) ________

How did you get injured? ____________________

Did your problems begin following: ☐ Work injury? ☐ Motor Vehicle Accident? What state? ________

How did you get injured? ____________________

If neither, how long have you had the condition? ________ First Noticed ________

Please rate your pain on a scale of 1 to 10 (10 being the most painful): ________

Is the pain: ☐ constant ☐ occasional ☐ sharp ☐ dull ☐ aching ☐ stabbing ☐ throbbing

What symptoms are you experiencing? ☐ locking ☐ catching ☐ giving way ☐ popping ☐ grinding ☐ other

What, if anything, makes the symptoms better? ____________________

What, if anything, makes the symptoms worse? ____________________

Have you seen another physician for this injury? ☐ yes ☐ no If yes, who? ________ Date ________

What treatments have you tried? ☐ Nothing ☐ Physical Therapy ☐ Exercise ☐ Acupuncture ☐ Chiropractic

☐ Injections (specify: ESI, facets, Sacroiliac, Selective Nerve Root Block, Synvisc, Hyalgan)

☐ Medications ____________________ ☐ Other ____________________

Have you had the following tests?

Test	Date (mm/yyyy)	What Facility?
☐ X-rays		
☐ MRI Scan		
☐ CT Scan		
☐ EMG/NCV		
☐ Discogram		
☐ EKG		
☐ Blood tests		
☐ Other		

Regular Exercise: ☐ yes ☐ no Type of exercise and activity you enjoy: ____________________

____

Patient Name ______________________________

PAST SURGICAL HISTORY

Please check a previous surgical procedure, list the date, and describe the surgery.

☐ Appendectomy ☐ Hernia Repair ☐ Arthroscopy: Lower Extremity Upper Extremity
☐ Spine/Back Surgery ☐ Heart Surgery ☐ Total Joint Replacement ☐ Fracture Repair
☐ Other: ______________________________

SOCIAL HISTORY

Special Diet: ☐ Yes ☐ No Any Restrictions? ______________________________
Tobacco Use: ☐ Yes ☐ No Type: ______________ Duration: ______________ Quit Date: __________
Alcohol Use: ☐ Yes ☐ No Frequency: ______________________________
Drug Use: ☐ Yes ☐ No Frequency: ______________________________
Caffeine Use: ☐ Yes ☐ No Frequency: ______________________________

ALLERGIES

Are you allergic to any medications? **Sulfa** ☐ Yes ☐ No **Latex** ☐ Yes ☐ No ☐ No known drug allergies

Please list all medications that you are allergic to: ______________________________
Please list food allergies (i.e. eggs, shellfish): ______________________________

MEDICAL HISTORY

☐ Anemia ☐ Depression ☐ Hepatitis A or B ☐ Osteoporosis
☐ Arthritis ☐ Diabetes ☐ High Blood Pressure ☐ Rheumatoid Arthritis
☐ Asthma ☐ Emphysema ☐ HIV ☐ Stroke/Seizures
☐ Blood Clots ☐ Heart Disease ☐ Irregular Heartbeat ☐ Thyroid
☐ Cancer ☐ Liver Disease ☐ Chemical Dependency ☐ Alcoholism
☐ Other______________________________

Have you ever had a blood transfusion? ☐ yes ☐ no If yes, when? ______________________________

MEDICATIONS

Please list all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any other counter medications. Include vitamins, minerals, and herb supplements.

Medication	Dosage	Frequency

GASTROINTESTINAL HISTORY

Do you have a history of Peptic Ulcer Disease? ☐ yes ☐ no If yes, when? ______________

Do you have a history of GI, stomach bleed? ☐ yes ☐ no If yes, when? ______________

Do you take any medications for your stomach? Please include over the counter medications (i.e. Pepcid, Tums, Xantac, etc.), dosage, and frequency. ______________________________

Have you ever taken anti-inflammatory medicine for a period greater than 30 days? (Please include all over the counter medications such as Advil, Aleve, and previously prescribed medications such as Celebrex and Vioxx. List all you have tried:

____
____

Patient Name ______________________________

FAMILY HISTORY

Please check family history conditions

☐ Blood clots ☐ Diabetes ☐ Hypertension ☐ Rheumatoid Arthritis
☐ Cancer ☐ Heart Disease ☐ Osteoporosis ☐ Stroke/Seizures

Please describe any immediate family history of medical problems: ______________________________

____

____

REVIEW OF SYSTEMS

Check id you have current symptoms or current known medical problems in the following areas. Please describe. If you do not have any problems, please check the negative/none box.

1. CONSTITUTIONAL GENERAL	☐ None	☐ Weight Loss	☐ Weight Gain	☐ Insomnia	☐ Chronic Fatigue
	☐ Other: ______				
2. EYES	☐ None	☐ Vision Change	☐ Glasses/Contacts	☐ Cataracts	☐ Glaucoma
	☐ Other: ______				
3. EARS, NOSE THROAT	☐ None	☐ Loss of hearing	☐ Seasonal Allergies	☐ Sinus Pain	☐ Ringing
	☐ Other: ______				
4. CARDIOVASCULAR	☐ None	☐ Chest Pain	☐ Edema	☐ Hypertension	☐ Palpitations
	☐ Other: ______				
5. RESPIRATORY	☐ None	☐ Asthma	☐ Wheezing	☐ Frequent Cough	
	☐ Other ______				
6. GASTROINTESTINAL	☐ None	☐ Heartburn	☐ Indigestion	☐ Acid Reflex	☐ Ulcers
	☐ Abdominal Pain	☐ Peptic Ulcer	☐ GI, Stomach Bleed		
	☐ Other: ______				
7. MUSCULOSKELETAL	☐ None	☐ Arthritis	☐ Muscle Weakness	☐ Joint Pain	☐ Back Pain
	☐ Other: ______				
8. SKIN	☐ None	☐ Rash	☐ Ulcers	☐ Scars	
	☐ Other: ______				
9. NEUROLOGICAL	☐ None	☐ Headaches	☐ Seizures	☐ Numbness	☐ Dizziness
	☐ Other: ______				
10. PSYCHIATRIC	☐ None	☐ Depression	☐ Crying	☐ Anxiety	☐ Mood Swing
	☐ Other: ______				
11. ENDOCRINE	☐ None	☐ Diabetes	☐ Hypothyroid	☐ Hyperthyroid	☐ Hot Flashes
	☐ Other: ______				
12. HEMATOLOGY	☐ None	☐ Easy Bruising	☐ Bleeding	☐ Anemia	
	☐ Other: ______				

Signature: ______________________________ Date: ______________

Print Name: ______________________________

Practitioner's Initials__________
Date _____/_____/_____