

Patient's Name: _____ Patient ID: _____ Date: _____

CURRENT INJURY OR PROBLEM

Please describe the reason for your visit today [What is injured, hurts or is bothering you]: _____

Onset Date [when did the injury or condition start?]: _____

How did it happen? _____

Where did it happen? Home Public School Work Auto Other: _____

Was this a result of an injury? Yes No Are you claiming this as work related? Yes No

Have you been seen by any other doctor for this injury/condition? Yes No

If yes, who? _____ When did you see the other doctor? _____

Have you had any of the following for this problem?

- CT MRI Bone Scans Occupational Therapy
- EMG X-Rays Physical Therapy Injections

Who was the doctor ordering these tests [If other than above]? _____

When and where were these treatments done? _____

Did you require surgery for this problem? Yes No

Have you had any previous difficulty or injury to this area? Yes No

If yes, please describe. _____

Primary Care MD? _____ Referring MD [if different]? _____

VITALS

What is your height? _____ What is your weight? _____

BP: _____ <div style="text-align: right; font-size: small;">Clinical Staff</div>
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PAST MEDICAL HISTORY

Please indicate if YOU have any of the following Problems:

- | | | |
|---|---|---|
| <input type="checkbox"/> Anesthesia
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Anemia
<input type="checkbox"/> Asthma
<input type="checkbox"/> Autoimmune
<input type="checkbox"/> Birth Defect
<input type="checkbox"/> Bleeding Disease
<input type="checkbox"/> Depression
<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Bruise easily | <input type="checkbox"/> Diabetes
<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Hepatitis A
<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Hepatitis C
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Reflux
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> TB (Tuberculosis)
<input type="checkbox"/> COPD/Emphysema
<input type="checkbox"/> Lupus
<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> GERD/Heartburn
<input type="checkbox"/> HIV
<input type="checkbox"/> Heart Disease/Heart Attack
<input type="checkbox"/> Other Illness: _____
<input type="checkbox"/> NONE |
|---|---|---|

Cancers:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Brain
<input type="checkbox"/> Breast
<input type="checkbox"/> Colon/Rectal | <input type="checkbox"/> Lung
<input type="checkbox"/> Liver
<input type="checkbox"/> Ovarian | <input type="checkbox"/> Prostate
<input type="checkbox"/> Skin
<input type="checkbox"/> Stomach | <input type="checkbox"/> Cervical
<input type="checkbox"/> Other Cancer:
<input type="checkbox"/> NONE |
|--|---|--|--|

Items not checked are understood to be negative

SURGERIES

Please list any surgeries you have had and their approximate date: _____

I have had no surgeries

FAMILY HISTORY

Please indicate if your parents or grandparents have had any of the following:

Anesthesia Problems Arthritis Heart Disease Bleeding Disease Birth Defects NONE Not

SOCIAL HISTORY

Occupation: _____ Handedness: Right Left Ambidextrous [Both]

Who are you living with? (Mark ALL that apply).

Spouse/Partner Parents Friends Nursing Home
 Alone Siblings Children In Retirement Community

How many children do you have? 0 1 2 3 4 5+

What is your current smoking status? Current Previous Never

What type of tobacco use: Cigarettes Cigars Smokeless/Chew Pipe How many/day [packs-if cigarettes]: ____

If you quit, when did you quit? _____

Do you drink alcohol? Yes No If yes, drinks per week: ____ Type(s) of Alcohol: _____

Do you exercise? Yes No If yes, how often: 1-3 times a week 3-5 times a week Daily

Please list any other medical problems: _____

MEDICATIONS

Please list current medications and doses. Include Prescriptions, Over-the-Counter, Herbal & Supplements [Attach list, if available].

Medication: _____	Dosage: _____
Medication: _____	Dosage: _____
Medication: _____	Dosage: _____
Medication: _____	Dosage: _____
Medication: _____	Dosage: _____
Medication: _____	Dosage: _____
Medication: _____	Dosage: _____
Medication: _____	Dosage: _____

Do you have any medication allergies? Yes No If yes, list medication and reaction:

Medication: _____	Reaction: <input type="checkbox"/> Rash/Hives <input type="checkbox"/> GI Upset <input type="checkbox"/> Anaphylactic	Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Critical
Medication: _____	Reaction: <input type="checkbox"/> Rash/Hives <input type="checkbox"/> GI Upset <input type="checkbox"/> Anaphylactic	Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Critical
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Patient's Signature _____ Date: _____