Please PRINT and fill out completely

Date: _____

Name: _____ **Date of Birth:** _____

Height: _____ Weight: _____ Hand Dominance: R / L

HISTORY OF INJURY

1) Did the problem result from a specific injury? ☐ Yes ☐ No
   If yes, Injury/Accident Date _____
2) Did your problems begin following: ☐ Work injury? ☐ Motor Vehicle Accident?
   If yes to MVA, in what state did said occur? _____
3) How did you become injured? _____
   _____
4) How long have you been experiencing these symptoms? _____
5) Please rate your pain, on a scale of 1 to 10, with 10 being the most painful.
   At Worst: 1 2 3 4 5 6 7 8 9 10
   At Rest: 1 2 3 4 5 6 7 8 9 10
6) Choose the words that best describe your pain:
   ☐ Constant OR ☐ Occasional
   ☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing ☐ Throbbing
7) What makes your symptoms *better*? _____
   What makes your symptoms *worse*? _____
8) Have you seen another physician for this injury? ☐ Yes ☐ No
   Is so, Physician name and phone number: _____
9) What treatments have you tried?
   ☐ None ☐ Physical Therapy ☐ Exercise ☐ Chiropractic ☐ Bracing
   ☐ Acupuncture ☐ Injections ☐ Medications
   ☐ Other (Please specify) _____
10) Have you had any of the following tests or studies?

	Test	Date	Which Facility?
☐	X-Ray		
☐	MRI		
☐	CT		
☐	EMG/NCV		

Social History

Recreational Activities: _____

Current Exercise Program: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed

Tobacco Use	☐ No	☐ Yes
Alcohol Use	☐ No	☐ Yes
Caffeine Use:	☐ No	☐ Yes
Recreational Drug Use:	☐ No	☐ Yes

Medical History

Are you Allergic to any Medications? ☐ No ☐ Yes

If **Yes**, please list: _____

Do you have a Latex Allergy? ☐ No ☐ Yes

Medications

Please list all medications you are currently taking. Please include any over the counter medications including vitamins and supplements.

Medication	Dosage	Frequency

Surgical History

Please list all surgeries you have had in the past.

Type of Surgery	Date	Surgeon

Past Medical History

Check box if you currently, or ever previously, suffered from any of the following:

Condition — When?

- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Gastritis
- ☐ GI Bleed
- ☐ Gout
- ☐ Heart Disease or Attack
- ☐ High Blood Pressure
- ☐ High Lipids
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Peptic Ulcer
- ☐ Polio
- ☐ Psoriasis
- ☐ Reflux Disease
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcer Disease
- ☐ Other

Family History

Please check if there is any history in your family of the following conditions and list their relation.

- ☐ Blood Clots
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease/Attack
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Renal Failure
- ☐ Rheumatoid Arthritis
- ☐ Stroke/Seizures

Review of Symptoms

Please complete the following, listing any symptoms you are currently experiencing.

1) General
   - ☐ None
   - ☐ Recent Weight Change ☐ Chills ☐ Fever ☐ Weakness/Fatigue
   - ☐ Other:

2) Eyes
- ☐ None
- ☐ Vision Change ☐ Cataracts ☐ Glaucoma
- ☐ Other: _____

3) Ear, Nose & Throat
- ☐ None
- ☐ Loss of Hearing ☐ Ear Ache/Infection ☐ Ringing in Ear ☐ Hoarseness
- ☐ Other: _____

4) Cardiovascular
- ☐ None
- ☐ Chest Pain ☐ Swelling in Legs ☐ Heart Murmur ☐ Palpitations
- ☐ Other: _____

5) Respiratory
- ☐ None
- ☐ Shortness of Breath ☐ Wheezing/Asthma ☐ Frequent Cough
- ☐ Other: _____

6) Gastrointestinal
- ☐ None
- ☐ Heartburn ☐ Acid Reflux ☐ Nausea/Vomiting ☐ Abdominal Pain
- ☐ Other: _____

7) Musculoskeletal
- ☐ None
- ☐ Arthritis ☐ Rheumatoid Arthritis ☐ Muscle Aches ☐ Gout
- ☐ Other: _____

8) Skin
- ☐ None
- ☐ Rash ☐ Ulcers ☐ Psoriasis ☐ Sores ☐ Abnormal Scars
- ☐ Other: _____

9) Neurological
- ☐ None
- ☐ Headaches ☐ Fainting/Blackouts ☐ Numbness/Tingling ☐ Dizziness
- ☐ Other: _____

10) Psychiatric
- ☐ None
- ☐ Depression ☐ Anxiety ☐ Mood Swing
- ☐ Other: _____

11) Endocrine
- ☐ None
- ☐ Excessive Thirst/Hunger ☐ Heat/Cold Intolerance ☐ Hot Flashes
- ☐ Other: _____

12) Hematological
- ☐ None
- ☐ Easy Bruising ☐ Easy Bleeding ☐ Anemia
- ☐ Other:

Patient or Authorized Signature _____ Date: _____ Time: _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)