PATIENT INFORMATION

Date: _____ **Name:** _____ **Age:** _____ **DOB:** _____

REASON FOR VISIT

Body Part(s): _____ ☐ **Right** ☐ **Left** ☐ **Bilateral**

Complaint: ☐ Pain ☐ Injury ☐ Fracture ☐ Numbness ☐ Swelling ☐ Other: _____

Have you or a family member been treated at the practice? ☐ **Self** ☐ **Spouse** ☐ **Parent(s)** ☐ **Sibling** ☐ **Child** ☐ **Aunt** ☐ **Uncle** ☐ **Other**_____

HISTORY OF PRESENT INJURY

(Please check all that apply)

Have you been off work for this problem?: ☐ Yes ☐ No **Dates off work**: _____

Doctors who have treated you for this problem: _____ **Did that doctor refer you here?**: ☐ Yes ☐ No

Primary Care Dr:_____ **Cardiologist**_____

Nephrologist (Kidney) Dr:_____ **Eye Doctor:** _____

Diagnostic tests and treatment performed *(please list when/where/what)* : ☐ X-Ray _____ ☐ MRI _____

☐ Injection _____ ☐ Surgery: _____ ☐ NSAIDS (anti-inflammatories) _____ ☐ EMG _____

☐ CT/Scan _____ ☐ Bone Scan _____ ☐ Lab Work _____ ☐ Other: _____ ☐ PT _____

Have you ever had similar problems? If yes, please give details: _____

Onset/Date of Injury: _____ **Context**: ☐ No Injury ☐ Injury ☐ Sports Injury ☐ MVA ☐ Work Injury

Details of Injury:_____

Severity: ☐ Mild ☐ Mild-Moderate ☐ Moderate ☐ Moderate-Severe ☐ Severe

Status: ☐ Changing ☐ Improving ☐ Fluctuating ☐ Resolved ☐ Stable ☐ Worse

Frequency: ☐ Intermittent ☐ Occasional ☐ Constant ☐ Rare

Quality: ☐ Aching ☐ Burning ☐ Dull ☐ Piercing ☐ Sharp ☐ Throbbing

Radiation: ☐ Yes ☐ No

Radiates To: _____

Associated Symptoms / Pertinent Negatives:

☐ Bruising
☐ Crepitus (cracking sounds)
☐ Decreased Mobility
☐ Difficulty going to sleep
☐ Instability
☐ Limping
☐ Locking
☐ Night Pain
☐ Night-time awakening
☐ Numbness
☐ Popping
☐ Spasms
☐ Swelling
☐ Tingling in the arms
☐ Tingling in the legs
☐ Tenderness
☐ Weakness
☐ Other: _____

Hand Dominance: ☐ Right ☐ Left

Aggravated By:_____

_____

Relieved By: _____

_____

REVIEW OF SYSTEMS

Do you have any of the following symptoms? *(Please check all that apply)*

Constitutional:
☐ Fatigue
☐ Fever
☐ Night Sweats

Cardiovascular:
☐ Chest Pain
☐ Cyanosis (blue color of skin)
☐ Irregular Heartbeats/Palpitations

Integumetary/Skin:
☐ Rash

Metabolic/Endocrine:
☐ Cold Intolerant
☐ Heat Intolerant

HEENT:
☐ Headache
☐ Vision Loss

Gastrointestinal:
☐ Constipation
☐ Diarrhea
☐ Nausea
☐ Vomiting

Neurological:
☐ Difficulty Walking
☐ Dizziness

Hematologic/Blood:
☐ Bleeding

Respiratory:
☐ Cough
☐ Dyspnea

Genitourinary:
☐ Dysuria
☐ Hematuria

Immunological:
☐ Enviromental Allergies
☐ Food Allergies

☐ **None**

PATIENT'S MEDICAL CONDITION

Height: ___ft ___in **Weight:** _____lbs **Blood Pressure:**_____/_____ **List details of any diet program:** _____

My weight in the last 6 months has: □ **Not Changed** □ **Increased** _____**lbs.** □ **Decreased** _____**lbs.**

ALLERGIES

Allergies to Medications/Foods/Other Products (i.e Latex, etc): _____

Reactions to Medications: _____

PATIENT'S MEDICAL HISTORY - Histories>Additional History

(Please check all that apply)

□ AIDS/HIV	□ COPD (Emphysema)	□ High Blood Pressure	□ Parkinson Disease	□ **None**
□ Alcoholism	□ Coronary Artery Disease	□ Hyperthyroidism	□ Peptic Ulcer Disease	
□ Alzheimers	□ Crohn's Disease	□ Hypothyroidism	□ Psoriasis	□ Other:
□ Anemia	□ Degenerative Joint Disease	□ Inflammatory Bowel Disease	□ PVD	
□ Angina	□ Depression	□ Juvenile Rheumatoid Arthritis	□ Renal Disease	_____
□ Arthritis	□ Drug Abuse	□ Kidney Disease Stg_____	□ Rheumatoid Arthritis	
□ Asthma	□ Diabetes (**see below**)	□ Liver Disease	□ Scoliosis	_____
□ Atrial Fibrillation	□ DVT (Blood Clot)/PE	□ Lyme Disease	□ Seizure Disorder	
□ Benign Prostatic Hypertrophy	□ Fibromyalgia	□ Migraine Headaches	□ Sleep Apnea	_____
□ Cancer	□ Gallbladder Disease	□ Multiple Sclerosis	□ SLE (Lupus)	
- Type_____	□ GERD	□ Myocardial Infarction	□ Spinal Stenosis	_____
-Treatment	□ Gout	□ Obesity	□ Thyroid Disease	
_____	□ Hepatitis	□ Osteoarthritis	□ Valvular Disease	_____
□ Cerebrovascular Accident (Stroke)	□ High Cholesterol	□ Osteoporosis	(Heart valve problems)	
□ Congestive Heart Failure (CHF)				

**** Diabetes** □ **Insulin** □ **Oral Medication Most Recent A1c: _____**

Date of Last Flu shot: _____ Date of Last Pneumonia shot:_____

Do you take a blood thinning medication (Warfarin, Plavix, Xarelto, Eliqus, Pradaxa, etc)? ___ Yes ___ No

Do you take a low dose aspirin (325mg or less) ? ___ Yes ___ No

Shoe Size: _____

PATIENT'S SURGICAL HISTORY - Please List

Date:_____ Surgery:_____ Date:_____ Surgery:_____

Date:_____ Surgery:_____ Date:_____ Surgery:_____

Date:_____ Surgery:_____ Date:_____ Surgery:_____

PATIENT'S FAMILY HISTORY - Histories> Additional Family History

Is your Father Living? □ Yes □ No If no, age deceased _____ cause of death _____

Is your Mother Living? □ Yes □ No If no, age deceased _____ cause of death _____

Are any of your brothers/sisters deceased? □ Yes □ No If yes, age deceased _____ cause of death _____

Family history of chronic/inherited diseases: _____

PATIENT'S SOCIAL HISTORY - Histories>Social History

Tobacco Use: □ Yes □ No □ Former/Year Quit _____ **Alcohol**: □ Yes □ No □ Former/Year Quit _____ Drinks/week_____

Activity Level: □ Sedentary □ Moderate □ Vigorous **Type of Exercise**: _____ _____

□ Disabled □ Retired □ Student **Type of Employment:**_____

SIGNATURE

Date: _____ **Signature of Patient, Parent or Guardian:** _____