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DEMOGRAPHICS:

Patient Name_____ Date: _____ DOB: _____ Age: _____ Male / Female

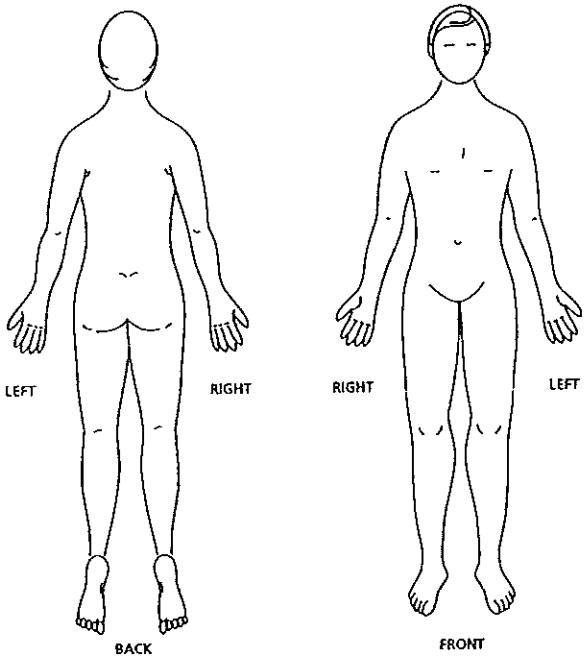
Occupation: _____ Ht: _____ Wt: _____ Marital Status: _____

Referred by: _____ PCP: _____ Hand Dominance: Right / Left

How did you hear about us? ☐ Referral ☐ Friend ☐ Internet ☐ Other _____

PAIN DIAGRAM: Please indicate areas of pain, numbness, tingling, and/or burning on the following diagram (2 body part limit):

Pain= P Numbness=N Tingling=T Burning=B



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Severity: How severe is your pain? (Circle #)

0	1 2 3	4 5 6 7	8 9 10
No Pain	Mild	Moderate	Severe

Nature: Pain is

☐ Occasional ☐ Continuous ☐ Intermittent

☐ Sharp ☐ Shooting ☐ Aching ☐ Dull

☐ Improving ☐ Worsening ☐ Unchanged

Pain is associated with:

☐ Clicking/Popping ☐ Numbness/Tingling

☐ Weakness

Does anything make it worse? _____

_____

Does anything make it better? _____

_____

What treatments have you done for this injury? _____

_____

REASON FOR VISIT:

Location of problem: ☐ Left ☐ Right ☐ Bi-Lat ☐ NA Body Part: _____

What is the main reason for today's visit? _____

_____

_____

_____

When did the injury occur? _____

How did the injury/symptoms occur? _____

_____

_____

What physical activities do you enjoy? _____

REVISED 03/16

PAST MEDICAL HISTORY:

			If Yes, Please Explain
Anemia	☐YES	☐NO	
Asthma/Bronchitis/Emphysema	☐YES	☐NO	
Arthritis	☐YES	☐NO	
Bleeding disorder	☐YES	☐NO	
Cancer (type)	☐YES	☐NO	
Diabetes (insulin dependent)	☐YES	☐NO	
Diabetes (non-insulin dependent)	☐YES	☐NO	
Heart Problems	☐YES	☐NO	
Hepatitis/Liver Disease	☐YES	☐NO	
High Blood Pressure	☐YES	☐NO	
Immune Disorder	☐YES	☐NO	
Kidney Problems	☐YES	☐NO	
Stomach/Intestinal Problems, Ulcers	☐YES	☐NO	

Other (please describe)_____

PAST SURGICAL HISTORY

Date	Procedure

ALLERGIES:

Please list any/all drug and food allergies including latex and metal:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

CURRENT MEDICATIONS:

Please list name, dosage of any medications you are taking currently including prescription, over-the-counter, herbals:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

SOCIAL HISTORY:

Alcohol Use: YES NO Occasionally

Tobacco Use: YES NO Packs Per Day: _____

Years: _____ Quit Date: _____

Smokeless Tobacco: YES NO Quit Date: _____

Illicit Drug Use: YES NO

Times Per Week: _____

FAMILY HISTORY:

Problem			Family Member
Diabetes	____ Y	____ N	
Heart Disease	____ Y	____ N	
Arthritis	____ Y	____ N	
Hip Problems	____ Y	____ N	
Other:			

REVIEW OF SYSTEMS:

			If Yes, Please Explain			
Good general health lately	☐YES	☐NO		Severe heartburn	☐YES	☐NO	
Recent weight changes	☐YES	☐NO		Abdominal pain	☐YES	☐NO	
Recurrent fever,chills,sweats,fatigue	☐YES	☐NO		Numbness or tingling	☐YES	☐NO	
Blurred or double vision	☐YES	☐NO		Breast pain or lump	☐YES	☐NO	
Breathing problems	☐YES	☐NO		Nervousness	☐YES	☐NO	
Heart trouble or heart attack	☐YES	☐NO		Depression	☐YES	☐NO	
Chest pain or angina	☐YES	☐NO		Back pain	☐YES	☐NO	
Shortness of breath	☐YES	☐NO		Excess thirst or urination	☐YES	☐NO	
Palpitations	☐YES	☐NO		Recent cold or flu	☐YES	☐NO	
Swelling of feet, ankles, or hands	☐YES	☐NO		Tetanus booster	☐YES	☐NO	
Blood clots	☐YES	☐NO		Frequent bleeding	☐YES	☐NO	
Varicose veins	☐YES	☐NO					