



Name: _____

Date of Birth: _____ Today's Date: _____

Age: _____ Dominant Hand: R L Height: _____ Weight: _____

Primary Care Physician (PCP): _____

Were you referred by a Physician? No Yes, who? _____

Chief Complaint: Why are you here today?

Did your problem result from a specific injury? No Yes, Date of injury: _____

Can you describe the injury? If no injury, how did the problem start?

Symptoms: What symptoms are you currently experiencing? (Please check all that apply)

- Pain Weakness Swelling Instability Stiffness / Motion Loss
- Locking Grinding Clicking Catching Numbness / Tingling
- Other: _____

Quality: Describe the symptoms: Sharp Stabbing Burning Shooting
 Dull Throbbing Achy Radiating

Duration: How long have you had symptoms? _____

Location: Where are your symptoms, specifically? _____

Timing: How often do you have symptoms? Occasional Frequent Constant
When do symptoms occur? At Rest With Activity Morning Night

Severity: (rate: 0=none to 10=severe, please circle) 0 · 1 · 2 · 3 · 4 · 5 · 6 · 7 · 8 · 9 · 10

What makes your symptoms *worse*? _____

What makes your symptoms *better*? _____

Have you had any prior injuries to the area? No Yes: _____

Previous Treatment: Have you had any prior treatment for this problem?

None Physical Therapy Medications: _____

Injections Chiropractor Surgery: _____

Have you had any tests for this problem? No X-rays MRI scan CT scan

When and where? _____

Past Orthopedic Injuries:

None _____

Medical History: (Please check previous or current medical conditions)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease/CAD | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stomach Ulcer/Reflux | <input type="checkbox"/> Stroke/Seizures |
| <input type="checkbox"/> Blood Clots/DVT | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Cholesterol | | |
| <input type="checkbox"/> COPD/Lung Disease | <input type="checkbox"/> HIV/AIDS | | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irregular Heartbeat | | |

Other: _____

Surgical History: (Please list ALL previous surgeries/operations and the dates they were performed)

None _____

Current Medications: (Please list names of all drugs and doses/amounts you are taking)

None _____

Allergies to Medications: Have you experienced an allergic reaction to any prescription drugs?

No Yes, Name of the drug? _____
What was the reaction? _____

Social History:

Marital Status: Single Married Divorced Widowed

Occupation: _____ Hobbies: _____

Do you smoke? No Yes: _____ packs/day for _____ years

Do you drink alcohol? No Rare Social Daily

Family History of Medical Conditions: (Please list any medical problems that run in your family)

None _____

Review of Systems: Do you experience any of these symptoms? (Please check all that apply)

- | | | | | |
|-----------------------------|---|---|---|---|
| 1. <i>General:</i> | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Insomnia |
| 2. <i>HEENT:</i> | <input type="checkbox"/> Vision change | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Sinus pain | <input type="checkbox"/> Sore throat |
| 3. <i>Cardiovascular:</i> | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Edema | <input type="checkbox"/> Poor circulation |
| 4. <i>Respiratory:</i> | <input type="checkbox"/> Cough | <input type="checkbox"/> Short of breath | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Pneumonia |
| 5. <i>Gastrointestinal:</i> | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Indigestion/Reflux | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| 6. <i>Genitourinary:</i> | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Difficult to urinate | <input type="checkbox"/> Painful to urinate | <input type="checkbox"/> Bloody urination |
| 7. <i>Skin:</i> | <input type="checkbox"/> Rash | <input type="checkbox"/> Hives | <input type="checkbox"/> Sensitive skin | <input type="checkbox"/> Easy scarring |
| 8. <i>Neurological:</i> | <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Seizures | <input type="checkbox"/> Tremor |
| 9. <i>Psychiatric:</i> | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Stress |
| 10. <i>Endocrine:</i> | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Hot flashes |
| 11. <i>Hematologic:</i> | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Easy bleeding | <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood clots |
| 12. <i>Immunologic:</i> | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Food allergy | <input type="checkbox"/> Infections | <input type="checkbox"/> Swollen glands |

Signature: _____ **Date:** _____

MD Signature: _____ **Date Reviewed:** _____