



### Patient History

Please Print and fill out completely

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

#### HISTORY OF PRESENT COMPLAINT

INJURY TO:  LEFT  RIGHT  BOTH

ARM  SHOULDER  ELBOW  WRIST  HAND

LEG  HIP  UPPER LEG  KNEE  ANKLE  FOOT

OTHER: \_\_\_\_\_

WHEN DID THE PROBLEM START? \_\_\_\_\_ IS THE PROBLEM WORK RELATED?  YES  NO

HOW DID THE PROBLEM BEGIN? (IF, YOU'RE UNSURE WHEN DID YOU FIRST NOTICE THE PROBLEM?) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

IS THE PAIN:  CONSTANT  OCCASIONAL  SHARP  DULL  ACHING  STABBING  THROBBING

DO YOU HAVE:  POPPING  LOCKING  CATCHING  GIVING WAY  OTHER: \_\_\_\_\_

PLEASE RATE YOUR PAIN ON A SCALE OR 1 TO 10 (10 BEING THE MOST PAINFUL)

*PLEASE MARK YOUR PAIN LEVEL BELOW*

I DO NOT HAVE ANY PAIN

MY PAIN COULD NOT BE WORSE



IS YOUR PAIN GETTING:  BETTER  SAME  WORSE

WHAT, IF ANYTHING, MAKES YOUR SYMPTOMS BETTER?  ICE  REST  ANTI-INFLAMMATORY MEDICATION

OTHER: \_\_\_\_\_

WHAT, IF ANYTHING, MAKES YOUR SYMPTOMS WORSE? \_\_\_\_\_

HAVE YOU SEEN ANOTHER PHYSICIAN FOR THIS PROBLEM?  NO  YES WHO? \_\_\_\_\_



PATIENT NAME: \_\_\_\_\_ DATE \_\_\_\_\_

WHAT TREATMENTS HAVE YOU TRIED?  NONE  PHYSICAL THERAPY  EXERCISE  ACUPUNCTURE  
 AMBULATORY AID  TOPICAL CREAM  CHIROPRACTIC  OTHER: \_\_\_\_\_

HAVE YOU HAD ANY INJECTIONS?  STEROID  VISCOSUPPLEMENT (HYALGAN, ORTHOVISC, ECT.)  OTHER: \_\_\_\_\_

HAVE YOU HAD ANY OF THE FOLLOWING TEST FOR THIS PROBLEM:

| TEST        | DATE | FACILITY |
|-------------|------|----------|
| XRAYS       |      |          |
| MRI SCAN    |      |          |
| CT SCAN     |      |          |
| EMG/ NCV    |      |          |
| DISCOGRAM   |      |          |
| EKG         |      |          |
| BLOOD TESTS |      |          |
| OTHER:      |      |          |

**CURRENT MEDICATIONS:**

PLEASE LIST ALL OF THE MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING OVER THE COUNTER MEDICATIONS AND DIETARY SUPPLEMENTS

| MEDICATION | DOSAGE | FREQUENCY |
|------------|--------|-----------|
|            |        |           |
|            |        |           |
|            |        |           |
|            |        |           |
|            |        |           |

**ALLERGIES:**  NONE  LATEX ALLERGY  ALLERGY TO ADHESIVE TAPE  
 YES, ALLERGIES TO THE FOLLOWING MEDICATIONS: \_\_\_\_\_

**SOCIAL HISTORY**

REGULAR EXERCISE:  NO  YES WHAT TYPE OF EXERCISE DO YOU ENJOY? \_\_\_\_\_

WHAT DO YOU DO FOR WORK? \_\_\_\_\_

HOBBIES? \_\_\_\_\_

TOBACCO USE:  NONE  YES, \_\_\_\_\_ PACKS A DAY FOR \_\_\_\_\_ YEARS  QUIT DATE: \_\_\_\_\_

ALCOHOL USE:  NONE  YES, DRINKS PER WEEK (ONE BEER = ONE DRINK, ECT): \_\_\_\_\_

OTHER (PLEASE INCLUDE RECREATIONAL DRUGS): \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE \_\_\_\_\_

**PAST SURGICAL HISTORY**

PLEASE LIST ALL PREVIOUS SURGICAL PROCEDURES AS WELL AS THE DATE AND SPECIFIC EXTREMITY IF APPLICABLE

| SURGICAL PROCEDURE | SIDE | DATE OF PROCEDURE |
|--------------------|------|-------------------|
|                    |      |                   |
|                    |      |                   |
|                    |      |                   |
|                    |      |                   |

**FAMILY HISTORY**

PLEASE INDICATE CONDITIONS THAT AFFECT MEMBERS OF YOUR FAMILY

- ARTHRITIS   
 CANCER   
 HEART DISEASE   
 OSTEOPOROSIS   
 BLOOD CLOTS   
 DIABETES  
 HYPERTENSION   
 STROKE/ SEIZURES   
 OTHER: \_\_\_\_\_

**REVIEW OF SYSTEMS**

PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS OR SYMPTOMS AND WHEN.

- GENERAL**     NONE     WEIGHT LOSS     WEIGHT GAIN     CHRONIC FATIGUE     OTHER: \_\_\_\_\_  
**WHEN:** \_\_\_\_\_
- EYES**     NONE     VISION CHANGE     CATARACTS     GLAUCOMA     GLASSES/CONTACTS     OTHER: \_\_\_\_\_  
**WHEN:** \_\_\_\_\_
- EARS, NOSE & THROAT**     NONE     HEARING LOSS     SINUS PAIN     RINGING IN THE EARS     SORE THROAT     SEASONAL ALLERGIES  
 OTHER: \_\_\_\_\_  
**WHEN:** \_\_\_\_\_
- CARDIOVASCULAR**     NONE     CHEST PAIN     EDEMA     HYPERTENSION     PALPATIONS     IRREGULAR HEART BEAT  
 HIGH CHOLESTEROL     HEART DISEASE     OTHER: \_\_\_\_\_  
**WHEN:** \_\_\_\_\_
- RESPIRATORY**     NONE     ASTHMA     WHEEZING     FREQUENT COUGH     EMPHYSEMA     OTHER: \_\_\_\_\_  
**WHEN:** \_\_\_\_\_
- GASTROINTESTINAL**     NONE     HEART BURN     INDIGESTION     ACID REFULX     ULCER PROBLEMS     ABDOMINAL PAIN  
 PEPTIC ULCER     BLOODY OR DARK STOOLS     OTHER: \_\_\_\_\_  
**WHEN:** \_\_\_\_\_
- MUSCULOSKELETAL**     NONE     ARTHRITIS     MUSCLE WEAKNESS     JOINT PAIN     BACK PAIN     OSTEOPOROSIS  
 RHEUMATOID ARTHRITIS     OTHER: \_\_\_\_\_  
**WHEN:** \_\_\_\_\_
- SKIN**     NONE     RASH     ULCERS     SCARS/KELOID     OTHER: \_\_\_\_\_  
**WHEN:** \_\_\_\_\_
- NEUROLOGICAL**     NONE     HEADACHES     SEIZURES     NUMBNESS     DIZZINESS     STROKE     OTHER: \_\_\_\_\_  
**WHEN:** \_\_\_\_\_
- PSYCHIATRIC**     NONE     DEPRESSION     CRYING     ANXIETY     MOOD SWINGS     CHEMICAL DEPENDENCY/ALCOHOLISM  
 OTHER: \_\_\_\_\_ **WHEN:** \_\_\_\_\_
- ENDOCRINE**     NONE     DIABETES     HYPOTHYROID     HYPERTHYROID     HOT FLASHES     OTHER: \_\_\_\_\_  
**WHEN:** \_\_\_\_\_
- HEMATOLOGY**     NONE     EASY BRUISING     BLEEDING     ANEMIA     BLOOD CLOT(S)     OTHER: \_\_\_\_\_  
**WHEN:** \_\_\_\_\_
- OTHER**     NONE     CANCER: TYPE \_\_\_\_\_     HEPATITIS     HIV     BLOOD TRANSFUSION  
 OTHER: \_\_\_\_\_ **WHEN:** \_\_\_\_\_