Name: _____**Date of Birth:**_____ _____Male _____Female **Date:** _____

Reason for Visit/Chief Complaint: _____

Any related injury or previous symptoms regarding your chief complaint?_____

Date of injury/Onset of symptoms?_____ Work Injury ☐ **Yes** ☐ **No**

How did your problem start? _____

How severe is your pain? (0 is pain free & 10 is the worst): 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? __Sharp __Dull __Throbbing __Aching __Burning The pain is: ____Constant ____Comes & Goes (intermittent)

Have you fallen in the past year?_____ If yes, how many times? _____ Did the fall result in injury? _____

Do you have: __Swelling __Bruising __Numbness __Weakness __Night Pain __Catching __Locking __Giving Way __Loss of bowel or bladder

What makes your symptoms worse? _____ Better?_____

Have you had a recent (within a year) x-ray on the affected area __yes __no Where? _____

Have you had a recent MRI / CT / Ultrasound on the affected area __ yes __ no Where? _____

REVIEW OF SYSTEMS

Constitutional
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain
- ☐ Weight Loss

HEENT
- ☐ Headache
- ☐ Hearing Loss
- ☐ Vertigo
- ☐ Vision Loss

Respiratory
- ☐ Cough
- ☐ Dyspnea

Cardiovascular
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Irregular Heartbeat/Palpitations

Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Genitourinary
- ☐ Dysuria
- ☐ Frequent Urination
- ☐ Urinary Incontinence

Metabolic/Endocrine
- ☐ Cold Intolerant
- ☐ Heat Intolerant

Neurological
- ☐ Dizziness
- ☐ Poor Coordination
- ☐ Memory Loss
- ☐ Seizures

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Integumentary
- ☐ Contact Allergy
- ☐ Itchy Skin
- ☐ Rash
- ☐ Skin Infections

Hematologic
- ☐ Bleeding
- ☐ Bruising

Immunological
- ☐ Contact Dermatitis
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Seasonal Allergies

PAST MEDICAL HISTORY

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimers
- ☐ Anemia
- ☐ Angina (chest pain)
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH (enlarged prostate)
- ☐ Cancer: _____
- ☐ CVA (stroke)
- ☐ Congestive Heart Failure
- ☐ COPD (emphysema)
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Degenerative Joint Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ DVT (blood clot)
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ GERD (reflux)
- ☐ Gout
- ☐ Hepatitis
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Inflammatory Bowel Disease
- ☐ Juvenile Rhumatoid Arthritis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lyme Disease
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ MI (heart attack)
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peptic Ulcer Disease
- ☐ Psoriasis
- ☐ PVD (vascular disease)
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ SLE (Lupus)
- ☐ Spinal Stenosis
- ☐ Spondyloarthropathy
- ☐ Thyroid Disease
- ☐ Valvular Disease

PAST SURGICAL HISTORY (PLEASE INDICATE WHICH SIDE WHERE APPLICABLE)

- ☐ ACL _____
- ☐ Angioplasty
- ☐ Angio w/stent
- ☐ Appendectomy
- ☐ Arthroscopy of _____
- _____
- ☐ Back Surgery_____
- ☐ Bypass
- ☐ Cardiac Valve Replacement
- ☐ Carpal Tunnel Release_____
- ☐ Cataract Removal
- ☐ Gallbladder
- ☐ Colectomy
- ☐ Discectomy
- ☐ Gastric Bypass
- ☐ Hernia Repair
- ☐ Hip Replacement_____
- ☐ Knee Replacement_____
- ☐ Laminectomy
- ☐ LASIK
- ☐ Meniscus Surgery_____
- ☐ Muscle Biopsy
- ☐ Fracture Fixation
- ☐ Pacemaker
- ☐ Rotator Cuff Repair_____
- ☐ Small Bowel Resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Ceserean Section
- ☐ Hysterectomy
- ☐ Mastectomy
- ☐ Other:

SOCIAL HISTORY

Age _____ Height _____ Weight _____ Hand Dominance __Right __Left

Race _____ Ethnicity: Hispanic / Non-Hispanic Preferred Language: _____

Occupation:_____ Activity: __Light __Moderate __Heavy

Tobacco:

☐ Current Everyday Smoker ☐ Current Some Day Smoker ☐ Former Smoker At what age did you quit? _____

☐ Never Smoked ☐ Unknown if Ever Smoked

Type: _Cigarette _Cigar _Chew/Snuff For how long: _____ years ____ Pack(s)/Can(s) per day/week

Alcohol:

Type: _____ Frequency:_____

FAMILY HISTORY (PLEASE INDICATE MOTHER, FATHER, BROTHER, AND/OR SISTER)

☐ None	☐ Coronary Artery Disease_____	☐ Gout _____	☐ Muscle Disease _____
☐ ADD/ADHD_____	☐ Colitis_____	☐ Hearing Impairment ____	☐ Obesity _____
☐ Alcoholism_____	☐ Congenital Heart Disease_____	☐ Heart Disease _____	☐ Osteoarthritis _____
☐ Allergies_____	☐ Congestive Heart Failure _____	☐ Hodgkins's Disease _____	☐ Osteoporosis _____
☐ Alzheimers_____	☐ COPD (emphysema)_____	☐ Hypertension _____	☐ Parkinson's Disease _____
☐ Anemia _____	☐ CVA (Stroke) _____	☐ Kidney Disease_____	☐ Peripheral Artery Disease _____
☐ Asthma_____	☐ Depression _____	☐ Learning Disability _____	☐ Renal Disease _____
☐ Blood Disease_____	☐ Developmental Delay _____	☐ Liver Disease_____	☐ Seizure Disorder _____
☐ Cancer: _____	☐ Diabetes _____	☐ Mental Illness _____	☐ Thyroid Disorder _____
_____	☐ Drug Abuse_____	☐ Migraines _____	☐ Other:_____

Allergies:

Medication	Reaction

Primary Care Physician: _____ Who referred you to us?_____

Other Physicians:_____

Have you had a pneumonia shot? _____ If so, when? _____

What pharmacy do you use? _____ City _____

Medications:

Name of Medication	Dose	Prescribing Physician