



Date: _____

Patient Name: _____

Date of Birth: _____ Height: _____ Weight: _____

Referred By: (First) _____ (Last) _____

Primary Physician: (First) _____ (Last) _____

Pharmacy: _____

Pharmacy Phone Number: _____

Chief Complaint

Right Left Bilateral Body Part _____

History of present illness (Answer these questions regarding your current problem(s) only.)

What symptoms are you experiencing? How did it happen? _____

Pain Description: Throbbing Burning Sharp Numbness Dull/Aching Shooting Pressure Tingling

On a scale of 0-10, how severe is your pain? (0 = no pain present, 10 = worst pain of your life) _____

Do any of the following activities make it worse? (Check all that apply)

Standing Exercise Lying Down Rising from a Chair Other: _____

Sitting Lifting Walking Activities of Daily Living _____

Do any of the following make it better? Medication Relaxation/Rest Other: _____

How long have you had this problem? What is the date of injury? _____

Is this a sports related injury? Yes No If yes, name the school/club: _____

Check any previous treatment(s) you've had for this problem, if applicable:

Emergency Room Physical Therapy Chiropractor Anti-Inflammatories/NSAIDs

Bracing Injection Surgery Other: _____

Have you had any of the following diagnostic studies for your current problem?

X-Rays Where: _____ When: _____

CT Where: _____ When: _____

MRI Where: _____ When: _____

Myelogram Where: _____ When: _____

Epidural steroid/injection Where: _____ When: _____

EMG/NCV Where: _____ When: _____

Work/Auto Related (Only if Applicable)

Is this a Workers' Compensation case? Yes No Date of Injury: _____

Is this a result of an auto accident? Yes No Date of Injury: _____

Do you have an attorney assisting you? Yes No

Is there any legal action pending? Yes No

Medications Please list all current medications and dosages, or bring current list to your scheduled appointment.

I am currently not taking any medications prescribed or over-the-counter.

Did you receive an influenza immunization this season? (October 1 - March 31) Yes No

Have you been discharged from a nursing facility, hospital or skilled rehabilitation facility in the last 30 days? Yes No

Allergies to Medications, X-Ray Dye, Metals and/or Soaps

No Known Allergies Yes (please list and indicate reaction): _____

Social History

Marital Status: Single Married Divorced Widowed Legally Separated
Employer: _____ Retired Disabled Unemployed
What kind of work do you do? _____
Are you a student? Yes No If yes, please list your grade and school name: _____
Do you exercise regularly? Yes No
Do you use any of the following? (check all that apply)
 Alcohol (Number of Drinks per day: _____) E-cigarettes or vapor cigarettes
 Cigarettes/Tobacco (Previous use? _____ Date Quit: _____) Non-prescription, mind-enhancing drugs
 Performance Enhancing Drugs (Please list: _____)

Past Medical History (Check all that apply)

Heart Disease Stroke Liver Disease Multiple Sclerosis
 Lung Disease Dementia Fibromyalgia Claustrophobia
 Asthma High Blood Pressure Gout Hepatitis A/B/C (circle one)
 Diabetes Cancer Skin Infection/MRSA HIV
 Gastric Ulcer Kidney Disease Cellulitis Reaction to Anesthesia
 Anxiety Blood Disorder Sleep Apnea/C-PAP Other _____
 Depression Thyroid Disorder Blood Clots/DVT Other _____
 Osteoarthritis Osteoporosis Pulmonary Embolism Other _____

Family History (Please check where applicable)

Heart Disease	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
High Blood Pressure	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
Stroke	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
Diabetes	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
Cancer	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
Bleeding/Clotting	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
Anesthesia Problems	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
Gout	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son

Procedure History (Please list all past procedures)

None Orthopaedic: (procedure & date) _____
 Stent Placement: (date) _____ Heart Bypass: (date) _____
 Pacemaker Hysterectomy Appendectomy Gall Bladder Sinus
 C-Section Tubal Ligation Tonsils Tubes (Ear) Vasectomy
 Other: _____

Review of Systems (Please mark current systems)

Constitutional <input type="checkbox"/> Normal <input type="checkbox"/> Obesity <input type="checkbox"/> Weight Change <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats	Endocrine <input type="checkbox"/> Normal <input type="checkbox"/> Excessive Sweating <input type="checkbox"/> Excessive Thirst	Neurologic <input type="checkbox"/> Normal <input type="checkbox"/> Vertigo/Dizziness <input type="checkbox"/> Motor Disturbances <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling	HEENT <input type="checkbox"/> Normal <input type="checkbox"/> Visual Problems <input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Headache <input type="checkbox"/> Tooth Pain	Gastrointestinal <input type="checkbox"/> Normal <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Heartburn/Acid Reflux
Psychiatric <input type="checkbox"/> Normal <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression	Cardiovascular <input type="checkbox"/> Normal <input type="checkbox"/> Chest Pain <input type="checkbox"/> Difficulty Breathing	Genitourinary <input type="checkbox"/> Normal <input type="checkbox"/> Urinary Incontinence <input type="checkbox"/> Urinary Frequency	Hematologic <input type="checkbox"/> Normal <input type="checkbox"/> Easy Bleeding <input type="checkbox"/> Easy Bruising	Skin <input type="checkbox"/> Normal <input type="checkbox"/> Rashes <input type="checkbox"/> Skin Lesions
Musculoskeletal <input type="checkbox"/> Normal <input type="checkbox"/> Other Joint Pain	Respiratory <input type="checkbox"/> Normal <input type="checkbox"/> Shortness of Breath	Allergies <input type="checkbox"/> Normal <input type="checkbox"/> Swollen glands in Neck <input type="checkbox"/> Seasonal Allergies		

Patient/Guardian Signature: _____ **Date:** _____

Reviewed by: _____