WEB 3469 West Elm Lima, Ohio 45807 567-940-9334

Date: _____ Patient Name: _____

Phone Number: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip:_____

Email: _____ Last 4 SSN: _____

Male Female Employment Status: _____ Employer: _____

Who may we thank for referring you? _____

Emergency Contact: _____Relation: _____ Phone: _____

Marital Status: Single Married Separated Divorced Widowed Spouse/Partner Name:_____

In a few sentences, please tell us what conditions you are seeking to be treated at our practice. Then, please put a number by them to indicate their priority with 1 being the biggest priority:

_____

_____

_____

_____

_____

Patient Name:_____ **Date:**_____

Complete all the questions below. Failure to do so may result in a reschedule of your appointment.

Describe your complaint: _____

Severity: ____/10 (10 being worst **History of:** Dislocation Tear Surgery Replacement Fracture Break _____

Date of first onset: approx. _____ **Believed to be caused by:**_____

Since it started the problem has: gotten better gotten worse stayed the same

What makes it worse: Movement Pressure **Other:** _____

Circle what you have tried that has helped: Ice Heat Brace Injection Drug Physical Therapy Massage Other:_____

Circle what you have tried that has NOT helped: Ice Heat Brace Injection Drug Physical Therapy Other: _____

How would you describe the problem? Tight Sharp Achy Dull Burning Numb Shooting Throbbing Diffuse Tingling

What percentage of time are you in discomfort? 10 20 30 40 50 60 70 80 90 100

Have you seen another doctor for this problem? Y N If yes, Treatment recommended:_____

Treatment Received: _____ Date:_____ Doctor or facility name:_____

Have you received an MRI or Xray for this problem? Y N Date:_____ Doctor or facility name:_____

Has this problem caused you to: Gain weight, Fall, Nausea, Loss of quality of life Other:_____

In order to properly assess your condition, we need to understand how this problem affects your everyday life. Complete at least 2 of the questions below. Examples have been provided to help you; you may circle the examples if they apply.

Due to this problem:

- I am unable to _____ without discomfort for more than ____ minutes Examples: walk, stand, drive, sleep
- I am unable to reach _____

Examples: above my head, my back pocket, to put socks or shoes on, to put a necklace on, to bend over to pick something up

- I have difficulty:_____

Examples: Hold a pen, open a jar, write a check, opening the gas tank

- I have difficulty:_____

Pressing the gas pedal, turning to look both ways at an intersection, getting out of the car, going up stairs/ downstairs

- I have difficulty:_____

Examples: picking up a bag of groceries, using a ladder, mowing the lawn, cooking, cleaning

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Indicate which of the below you have, have experienced or have been diagnosed with:

Eyes/Ears/Nose/Throat/Respiratory		Muscular Skeletal		Neurological		General	
Asthma		Muscle Aches		Headaches		Fatigue	
Stuffy Nose		Bursitis		Migraines		Malaise	
Shortness of breath / Wheezing		Arthritis		Dizziness		Weakness	
Sore throat		Joint Pain		Numbness		Lightheadedness	
Chronic Cough		Low Back Pain		Tingling		Irritability	
Chest Congestion		Neck Pain		Pins/needles		Weight Gain	
Frequent Sneezing		Wrist/Hand Pain		Fibromyalgia		Sleep Apnea	
Itchy Watery Eyes		Elbow Pain		Neuropathy		Cancer	
Drainage		Shoulder Pain		Alzheimer's		Skin	
Earache Ear Infection		Hip Pain		Dementia		Growths	
Itching		Knee Pain		Anxiety		Eczema	
Hoarseness		Ankle/ Foot Pain		Depression		Rashes/ Sores	
Macular Degeneration		Pain b/t shoulders		Mood swings		Un-healing wounds	
Cataracts		Torn Muscle/Tendon		Seizure		GenitoUrinary	
Glaucoma		Paget's Disease		Poor memory		Sexual Dysfunction	
Cataracts		Torn Ligament		Gastrointestinal		Urinary Frequency	
Root Canal		Joint Replacement		Bloody Stool		Bladder Leakage	
Mercury Fillings		Spinal Fusion		IBS		Immunology	
Cardiovascular		Spinal Implant		Constipation		Autoimmune Disease	
Anemia		Spondylolisthesis		Diarrhea		Immunocompromised	
Sickle Cell		Osteoporosis		Acid Reflux		Seasonal Allergies	
Heart Disease		Restricted Motion		Chron's Disease		Recurrent Infections	
High Cholesterol		Endocrine		Abdominal Pain		Allergic Reaction	
Thrombosis		Hormonal Imbalance		Office Use:			
Anticoagulant Use		Thyroid Issues					
Palpations / Arrhythmia		Menopause					
Mitral Valve Prolapse		Ovarian Cysts					
Pacemaker		Hypogonadism					
Clotting Issues		Diabetes					
Heart Attack		Kidney Disease					
Abnormal Platelet Function		Liver Disease					
Coagulation disorder		Hot Flashes					
Varicose Veins		Low Libido					
Swelling of feet or hands		Hysterectomy		Provider Review:			
Chest Pain or Pressure		Heat/Cold Intolerance		Other:			
Shortness of Breath		Excessive Thirst		Other:			

Patient Name:_____ Date:_____

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____

_____

_____

Medications: (include nonprescription)

Name: Reason: Frequency & Amount: Prescribing Provider:

_____

_____

_____

_____

_____

_____

Allergies_____sulpha_____pork ___egg products ___feathers or avian (bird) proteins

_____

_____

Social History:

Use of Alcohol: How many drinks do you have in a week?_____

Tobacco: How Often do you smoke?_____How many years ago did you start smoking?_____
What kind of tobacco product(s) do you use?_____Do you want to quit? Y N
Have you smoked on a daily basis in the past? How many years ago did you quit?_____

Use of Drugs Never: _____ Type:_____ Frequency: _____

Excessive Exposure at home or at work to (circle): Fumes Dust Solvents Airborne Particles Noise

Exercise Type:_____Frequency:_____

Family Medical History: Age Disease If Deceased, Cause of Death

Relation:_____
Relation:_____
Relation: