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Today's Date: __________________

PATIENT

First Name:	Middle:	Last Name:	Date of Birth:	Age:
Date of Injury:	Height:	Weight:	Gender:	
SSN:	Ethnicity:	Language:	Marital Status:	
Mailing Address:		City:	State:	Zip Code:
Home Phone:	Cell Phone:		Work Phone:	
Email Address:		Occupation:		
Employer:		Employer Phone:		
Employer Address:		City:	State:	Zip Code:
Primary Care Physician:	Phone:	Referring Physician:	Phone:	
Preferred Pharmacy:	Pharmacy Phone:	Pharmacy Address:		

EMERGENCY CONTACT INFORMATION

Emergency Contact:	Relation:	Emergency Contact Phone Number:

MEDICATIONS (Past and Current)

Medication	***Dose***	***Route***	***How often?***

ALLERGIES

HISTORY OF HOSPITALIZATIONS AND SURGERIES

Type	***Year***	***Type***	***Year***

SOCIAL HISTORY

Do you live alone? □ Yes □ No	Do you have children? □ Yes □ No	Occupation:

How often do you consume alcohol?	How often do you exercise?

Do you currently smoke? □ Yes □ No	If yes, how often do you smoke? Everyday Sometimes, but not every day	How many cigarettes do you smoke per day? 5 or less 6 - 10 11 - 20 21 - 30 31 or more
How long have you been smoking?	Are you interested in quitting?	Do you use any other form of tobacco?

FAMILY MEDICAL

Heart disease:	□ Mother	□ Father	□ Sibling
Hypertension/High Blood Pressure:	□ Mother	□ Father	□ Sibling
High Cholesterol:	□ Mother	□ Father	□ Sibling
Multiple allergies or	□ Mother	□ Father	□ Sibling
Depression:	□ Mother	□ Father	□ Sibling
Cancer:	□ Mother	□ Father	□ Sibling
Diabetes:	□ Mother	□ Father	□ Sibling
Other:			

SYSTEM REVIEW	SYMPTOMS (Please Circle)
General	*Fatigue, fever, night sweats, sleep disturbance, swollen glands, weight gain, weight loss*
Allergy	*Congestion, itching, rash, wheezing*
Ophthalmology	*Blurred-vision, dry-eye, pain*
ENT	*Sinus pain, swollen glands*
Endocrinology	*Cold intolerance, excessive sweating, frequent urination, low sugar, high sugar*
Respiratory	*Cough, hemoptysis, shortness of breath, sputum production*
Cardiovascular	*Chest pain, difficulty lying flat, dizziness, irregular heartbeat, palpitations*
Gastrointestinal	*Blood in stool, constipation, diarrhea, heartburn*
Hematology	*Easy bruising, history of transfusion, prolonged bleeding*
Women-Only	*Excessive bleeding, irregular menses, pain with urination, post-menopausal*
Men-Only	*Difficulty with urination, getting up at night to urinate, pain with urination, scrotal lumps*
Musculoskeletal	*Difficulty walking, history of fracture, joint injection, joint stiffness, joint swelling, muscle aches, uses aids*
Peripheral Vascular	*Cold extremities, cramping in the legs while walking, ulceration of hands or feet*
Skin	*Keloid formation, rash, skin lesions*
Neurologic	*Balance difficulty, headache, memory loss, numbness, seizures, tingling, tremors*
Psychiatric	*Delusion, depressions, eating disorder, panic attacks, street drug usage.*

PAST MEDICAL HISTORY (Please check boxes that apply to you)

Condition		Condition	
AIDS/ HIV		High Cholesterol	
Anemia		Hypertension	
Anxiety/Depression		Kidney Disease	
Arthritis		Liver Disease	
Asthma		Migraines	
Bleeding Disorder		Orthotics	
Blood Clot		Osteoporosis	
Blood Transfusion		Pacemaker	
COPD		Peripheral vascular disease	
Cancer: type________________		Pulmonary Embolism	
Coronary Artery Disease		Rheumatoid Arthritis	
Diabetes		Seizures/ Epilepsy	
Gout		Stroke	
Heart Attack (MI)		Thyroid problems	
Heart Problems		Tuberculosis	
Hepatitis		Ulcers	
Hernia		Other:	

REASON FOR VISIT (HPI)

Please provide the approximate date in which you were first aware of this problem (Duration):

□ Don't remember □ Several years ago □ Several months ago □ Several days ago

Hand dominance (circle):	**RIGHT**	**LEFT**

Location of complaint (circle): **RIGHT/LEFT**, finger, hand, wrist, or arm?	Does the problem interfere with activities? (Yes/No)
What makes the symptoms better?	What makes the symptoms worse?
Date the symptoms began:	Was the problem caused by injury or accident? (Yes/No)
Details of the injury:	If open wound, date of last tetanus shot:

Previous treatment for injury/illness stated above that you are being seen for today:			
Emergency Room:	□ Yes	□ No	Location:
Doctor's Office:	□ Yes	□ No	Name of Doctor:

What treatment was prescribed for this problem? (Please check all that apply)					
□ Therapy	□ Cast	□ Brace	□ Splint	□ Sling	□ Rest

Have any X-Rays, MRIs, CT's or any other diagnostic test been performed for this injury? Please circle.	Describe the pain (circle): dull, throbbing, sharp
Previous problems of a similar nature:	What is the severity of your pain from 0 to 10?

What **problem** would you like us to address today?

Vocation:
Employer:
Attorney:

Is this problem because of an **injury**? Yes No

If Yes: MVA Work Sports Other

Date of injury:

Describe injury:

Is there a work claim? Yes No

If you have **pain**, please locate and rate your **pain** on the diagrams

How long have you had pain / discomfort? Days Weeks Months Years

Please **describe** your pain: Sharp Burning Pins/needles Pressure Throbbing Ache / Deep Stiff Numb Clicking/Popping

When do you feel pain? Morning Work/Activity Driving Sports Startup Evening Night/Sleep

What **improves** or **worsens** your pain: