Patient name_____ Date_____

Reason for Visit (i.e. body part) _____ right left bilateral

Date of onset_____

Where did injury happen? (Home, work)_____

How did injury happen? _____
_____
_____

Pain type is: (circle all that apply)
Aching
Burning
Numbness
Sharp
Throbbing
Other_____

Pain is aggravated by: (circle all that apply)
Bending
Climbing stairs
Descending stairs
Lifting
Pushing
Sitting
Standing
Walking
Other_____

Pain is relieved by: (circle all that apply)
Brace
Elevation
Heat
Ice
Medications (type) _____
Exercise
Injection (type) _____
Massage
Rest
Stretching
Other_____

PLEASE CONTINUE TO OTHER SIDE

Symptom Review

If you currently have any of the following, please check all that apply

Fever ☐

Sore Throat ☐

Nasal Congestion ☐

Shortness of Breath ☐

Chest Pain ☐

Abdominal Pain ☐

Easy Bruising ☐

Blood in Urine ☐

Rash ☐

Anxiety ☐

Patient name: _____

Please list all current Medications you are on: Check here if none ☐

Medication:	Strength:	Taking how many times a day:

MEDICAL HISTORY

Check here if none ☐

___ aids/HIV
___ alcoholism
___ Alzheimer's
___ (chest pain) angina
___ arthritis
___ asthma
___ atrial fibrillation (irregular heartbeat)
___ benign prostatic hypertrophy(BPH)
___ bleeding disorder
___ cancer (type) _____
___ (stroke) cerebrovascular accident
___ congestive heart failure
___ COPD (ex. Emphysema)
___ coronary artery disease
___ Crohn's disease
___ degenerative joint disease
___ depression
___ diabetes
___ drug abuse
___ DVT (blood clot)
___ fibromyalgia
___ gallbladder disease
___ GERD (heartburn, reflux)
___ gout
___ hepatitis
___ hyperlipidemia
___ (high blood pressure) hypertension
___ inflammatory bowel disease
___ juvenile Rheumatoid Arthritis
___ kidney disease
___ liver disease
___ lyme disease
___ migraine headaches
___ multiple sclerosis
___ aneurysm
___ (heart attack) myocardial infarction
___ obesity
___ osteoarthritis
___ osteoporosis
___ parkinson disease
___ peptic ulcer
___ psoriasis
___ PVD (vascular disease)
___ Rheumatoid Athritis
___ scoliosis
___ seizure disorder
___ sleep apnea
___ SLE (lupus)
___ thyroid disease
___ valvular disease (heart)

Any additional medical history:

_____

_____

_____

Please list all Medical Related Allergies: Check here if none ☐

Medication:	Reaction:

SURGICAL HISTORY check here if none ☐

	Side	Year		Side	Year
___ ACL surgery	_____	_____	___ gastric bypass	_____	_____
___ angioplasty	_____	_____	___ hernia repair	_____	_____
___ appendectomy	_____	_____	___ hip replacement	_____	_____
___arthroscopy ankle	_____	_____	___ knee replacement	_____	_____
___arthroscopy elbow	_____	_____	___ shoulder replacement	_____	_____
___arthroscopy hip	_____	_____	___ LASIK	_____	_____
___arthroscopy knee	_____	_____	___ pacemaker	_____	_____
___arthroscopy shoulder	_____	_____	___ rotator cuff repair	_____	_____
___ back/spine surgery	_____	_____	___ small bowel resection	_____	_____
	_____	_____	___ thyroidectomy	_____	_____
type_____			___ tonsillectomy	_____	_____
___ CABG (heart bypass)	_____	_____			
___ cardiac valve replacement	_____	_____	Gender specific		
___ carpal tunnel release	_____	_____	___ cesarean section	_____	_____
___ cataract	_____	_____	___hysterectomy	_____	_____
___ (gallbladder removal) cholecystectomy		_____	___ mastectomy	_____	_____
___ colectomy	_____	_____	___ tubal ligation		_____
___ colostomy (exterior bowel pack)		_____			

Have you ever had a fracture that needed surgery? What body part broken?

_____

_____

Any additional surgeries:

_____

_____

Family history check here if none ☐

Family member	Disease

Tobacco use: yes no quit Year quit: _____
Type of tobacco: (chewing) (cigar) (cigarettes) (pipe) (smokeless)
Years of use: _____ Amount of tobacco: _____ (packs, bowls, can) a day

Height _____ Weight _____