



Today's date: ____/____/____

1. Name: _____ Date of Birth: ____/____/____
2. Your age: _____ Approximate weight: _____ Approximate height: _____
3. How were you referred to our office?
 Physician: _____ Patient: _____
 I am a prior patient Insurance website Online Other: _____
4. X-ray/MRI/CT scan (check all that apply):
 performed today Outside facility: _____ disk brought in today
5. Chief complaint(s) (*What brings you in today?*): _____
6. Duration (*How long* have you had your problem?):
____ days or ____ weeks or ____ months or ____ years injury date: _____
7. Location (*Where* is the problem located?):
 RIGHT LEFT Shoulder Elbow Hand Neck
 Hip Knee Ankle Back
8. Complaint (*Describe* your problem. Please check all that apply.):
 Pain Swelling Catching Instability Other: _____
9. Frequency (*How often* do you have your problem?):
 Constant Intermittent Activities only At rest Other: _____
10. Timing (*When* does this problem occur?):
 Daytime Nighttime Work Sports "Activities of Daily Life"
 Morning End of the day Other: _____
11. Modifying factors (*What makes* your symptoms better?):
 Ice Rest Positional changes Activity modification (avoidance)
12. Previous treatments (*How has* your problem been treated in the past?):
 Advil®/Motrin®/Aleve® Tylenol® tramadol hydrocodone oxycodone
 Physical Therapy (Location: _____ Duration: _____)
 Injections (last received: _____) Chiropractor
 Other: _____

Medications you are currently taking **with** dosage and frequency:

Preferred Pharmacy (Name, Address, Phone #):

Allergies AND Reactions:

Medical History:

Alcoholism	Yes No	Gout	Yes No	Liver Disease	Yes No
Anesthetic Complications	Yes No	Heart Disease	Yes No	Lung Disease	Yes No
Autoimmune Disease	Yes No	Hepatitis	Yes No	Osteoarthritis	Yes No
Cancer	Yes No	HIV/AIDS	Yes No	Osteoporosis	Yes No
Clotting Disorder	Yes No	Hyperlipidemia	Yes No	Stroke	Yes No
Deep Vein Thrombosis	Yes No	Hypertension	Yes No	Thyroid Disease	Yes No
Diabetes	Yes No	Infectious Disease	Yes No	Other:	
Fractures	Yes No	Kidney Disease	Yes No	Other:	

Surgical History:

Ankle Surgery	L R	Yes No	Hand Surgery	L R	Yes No	Shoulder Replacement	L R	Yes No
Back Surgery		Yes No	Heart Surgery		Yes No	Shoulder Surgery	L R	Yes No
Carpal Tunnel	L R	Yes No	Hip Replacement	L R	Yes No	Spinal Fusion		Yes No
Elbow Surgery	L R	Yes No	Knee Arthroscopy	L R	Yes No	Wrist Surgery	L R	Yes No
Foot Surgery	L R	Yes No	Knee Replacement	L R	Yes No			
Other:								

Family History:

	Anesthetic Drugs	Cancer	Clotting Disorder	Diabetes	Deep Vein Thrombosis	Gout	Heart Disease	Hepatitis	HIV/AIDS	Hypertension	Kidney Disease	Liver Disease	Lung Disease	Osteoarthritis	Osteoporosis	Stroke
Father																
Mother																
Sibling																

Social History:

Tobacco Use:	Yes No	If Former Smoker, Year Quit:	# Packs Per Day:
Smokeless Tobacco Use:	Yes No	Type:	
Alcohol Use:	Yes No	Socially Occasionally Daily Never	
Drug Use:	Yes No	Type:	# of Uses Per Week: