Name: _____

Date of Birth: _____ Today's Date: _____

Age: _____ Dominant Hand: ◻ R ◻ L Height: _____ Weight: _____

Primary Care Physician (PCP): _____

Were you referred by a Physician? ◻ No ◻ Yes, who? _____

Chief Complaint: Why are you here today?

_____

_____

Did your problem result from a specific injury? ◻ No ◻ Yes, Date of injury: _____

Can you describe the injury? If no injury, how did the problem start?

_____

_____

Symptoms: What symptoms are you currently experiencing? (Please check all that apply)

◻ Pain ◻ Weakness ◻ Swelling ◻ Instability ◻ Stiffness / Motion Loss
◻ Locking ◻ Grinding ◻ Clicking ◻ Catching ◻ Numbness / Tingling

◻ Other: _____

Quality: Describe the symptoms: ◻ Sharp ◻ Stabbing ◻ Burning ◻ Shooting
◻ Dull ◻ Throbbing ◻ Achy ◻ Radiating

Duration: How long have you had symptoms? _____

Location: Where are your symptoms, specifically? _____

Timing: How often do you have symptoms? ◻ Occasional ◻ Frequent ◻ Constant
When do symptoms occur? ◻ At Rest ◻ With Activity ◻ Morning ◻ Night

Severity: (rate: 0=none to 10=severe, please circle) 0 · 1 · 2 · 3 · 4 · 5 · 6 · 7 · 8 · 9 · 10

What makes your symptoms *worse*? _____

What makes your symptoms *better*? _____

Have you had any prior injuries to the area? ◻ No ◻ Yes: _____

Previous Treatment: Have you had any prior treatment for this problem?

◻ None ◻ Physical Therapy ◻ Medications: _____

◻ Injections ◻ Chiropractor ◻ Surgery: _____

Have you had any tests for this problem? ◻ No ◻ X-rays ◻ MRI scan ◻ CT scan

When and where? _____

Past Orthopedic Injuries:

□ None _____

Medical History: (Please check previous or current medical conditions)

□ None	□ Anemia	□ Diabetes	□ Liver Disease
	□ Arthritis	□ Heart Disease/CAD	□ Osteoporosis
	□ Asthma	□ Hepatitis	□ Prostate
	□ Blood Clots/DVT	□ High Blood Pressure	□ Stomach Ulcer/Reflux
	□ Cancer _____	□ High Cholesterol	□ Stroke/Seizures
	□ COPD/Lung Disease	□ HIV/AIDS	□ Thyroid Disease
	□ Depression	□ Irregular Heartbeat	□ Vascular Disease

□ Other: _____ _____ _____

_____ _____ _____

Surgical History: (Please list ALL previous surgeries/operations and the dates they were performed)

□ None _____ _____ _____

_____ _____ _____

Current Medications: (Please list names of all drugs and doses/amounts you are taking)

□ None _____ _____ _____

_____ _____ _____

Allergies to Medications: Have you experienced an allergic reaction to any prescription drugs?

□ No □ Yes, Name of the drug? _____ _____

What was the reaction? _____ _____

Social History:

Marital Status: □ Single □ Married □ Divorced □ Widowed

Occupation: _____ Hobbies: _____

Do you smoke? □ No □ Yes: ____ packs/day for ____ years

Do you drink alcohol? □ No □ Rare □ Social □ Daily

Family History of Medical Conditions: (Please list any medical problems that run in your family)

□ None _____

Review of Systems: Do you experience any of these symptoms? (Please check all that apply)

1.	*General:*	□ Fatigue	□ Weight gain/loss	□ Fever/Chills	□ Insomnia
2.	*HEENT:*	□ Vision change	□ Hearing loss	□ Sinus pain	□ Sore throat
3.	*Cardiovascular:*	□ Chest pain	□ Palpitations	□ Edema	□ Poor circulation
4.	*Respiratory:*	□ Cough	□ Short of breath	□ Wheezing	□ Pneumonia
5.	*Gastrointestinal:*	□ Nausea/Vomiting	□ Indigestion/Reflux	□ Diarrhea	□ Constipation
6.	*Genitourinary:*	□ Frequent urination	□ Difficult to urinate	□ Painful to urinate	□ Bloody urination
7.	*Skin:*	□ Rash	□ Hives	□ Sensitive skin	□ Easy scarring
8.	*Neurological:*	□ Headache	□ Dizziness	□ Seizures	□ Tremor
9.	*Psychiatric:*	□ Depression	□ Anxiety	□ Mood swings	□ Stress
10.	*Endocrine:*	□ Hypoglycemia	□ Diabetes	□ Thyroid	□ Hot flashes
11.	*Hematologic:*	□ Easy bruising	□ Easy bleeding	□ Anemia	□ Blood clots
12.	*Immunologic:*	□ Seasonal allergies	□ Food allergy	□ Infections	□ Swollen glands

Signature: _____ Date: _____

MD Signature: _____ Date Reviewed: _____