PATIENT MEDICAL HISTORY

(Please fill out completely to avoid a delay being seen)

NAME: _____ **AGE:** _____ **GENDER:** _____

HEIGHT: _____ **WEIGHT:** _____ **MARITAL STATUS:** ☐Married ☐Single ☐Other

☐ Right-handed ☐Left-handed **REFERRED BY:** ☐ **OTHER** _____

PCP DR: _____ **PHONE#:** _____ **FAX #:** _____

REF. DR: _____ **PHONE#:** _____ **FAX #:** _____

Chief Complaint: ☐**R** ☐**L** _____ ****We will only see 1 body part at each visit****

How did you injure yourself? _____**Date of injury:**_____

☐**My medical problem *IS* related to a work injury.** **Date of Injury:**_____

☐**My medical problem *IS* related to a motor vehicle accident.** **Date of accident:**_____

Occupation: _____ ☐Full-Time ☐ Student ☐Retired

- Are you currently working? ☐YES ☐NO-Last day: _____ ☐ Unemployed ☐ Disabled
  - Reason not working:_____

PAIN AND SYMPTOMS OF CURRENT CHIEF COMPLAINT

☐Numbness/Tingling
☐Swelling
☐Radiating Pain
☐Pain while walking/bearing weight
☐Trouble sleeping (Pain)
☐Limited Range of motion
☐Predominantly leg pain
☐Catching/locking
☐ Giving Way Episodes
☐Pain climbing stairs
☐Popping/Clicking (audible)
☐ Increased pain with activities of daily living (Bathing, grooming, mobility, eating, dressing, dressing, etc)
☐Weakness
☐Predominantly back pain
☐Bowel/bladder changes
☐Pain while standing
☐Pain while sitting
☐Pain increased w/ activity

☐ **What is your pain level? (0-10)** _____

TREATMENT YOU HAVE HAD FOR CURRENT INJURY

☐ Casting
☐ Epidural Steroid Injections
☐ Oral Steroids
☐ EMG
☐ X-rays
☐ Nerve Root Blocks
☐ Bonescan
☐ Discogram
☐ Rest
☐ Pain Medication
☐ Weight loss
☐Assistive device/ Splinting/Bracing
☐ CT/Myelogram
☐ Muscle Relaxers
☐ MRI
☐ Chiropractic Treatment
☐ Home exercise program

☐Anti-inflammatory meds-Advil, Aleve, etc (If so, for how long?) _____ Did these help? ☐ Y ☐ N
☐ Cortisone injection (s) How many? _____ Did this provide relief? ☐ Y ☐ N
☐ Physical Therapy If so, when _____ And was this for 12 weeks or longer? ☐ Y ☐ N Length: _____

SOCIAL HISTORY

Do you use tobacco products? ☐ YES ☐NO (cigarettes, chewing tobacco/cigars) Previous user: ☐Y or ☐N
Do you drink alcohol? ☐ YES ☐NO
Is there any chance you could be pregnant? ☐YES ☐NO Date of last menstrual period? _____

Please list **ALL Medications** with dosages (Prescription, Vitamins, Herbal) ☐ **NONE** ☐ **See attached list:**

_____

_____

Please list **ALL Allergies** to any Medications, Latex, Tapes, Etc.: ☐ **NONE**

_____

_____

Please list **ALL types of Surgeries** you have had & the Year- ☐ **NONE**

_____

_____

Please mark for any medical conditions YOU suffer from:

☐ Alcoholism	☐ Diabetes	☐ High Blood Pressure	☐ Scoliosis
☐ Arthritis	☐ Fibromyalgia	☐ Kidney Disorder	☐ Seizures
☐ Asthma	☐ HIV Infection	☐ Liver Disease/Jaundice	☐ Stroke
☐ Bladder/Prostate Problems	☐ Heart Attack	☐ Lupus	☐ Tuberculosis
☐ Blood Clots	☐ Heart Problems	☐ Multiple Sclerosis	☐ Ulcers
☐ Cancer	☐ Hepatitis	☐ Polio	☐ Weakness or Paralysis
☐ Frequent headache/Migraine	☐ Sleep apnea	☐ Depression	☐ Anxiety or nervousness
☐ History of Gout	☐ Thyroid Problems		

Please mark for any conditions YOUR FAMILY suffers from:

☐ Alcoholism	☐ Diabetes	☐ High Blood Pressure	☐ Scoliosis
☐ Arthritis	☐ Fibromyalgia	☐ Kidney Disorder	☐ Seizures
☐ Asthma	☐ HIV Infection	☐ Liver Disease/Jaundice	☐ Stroke
☐ Bladder/Prostate Problems	☐ Heart Attack	☐ Lupus	☐ Tuberculosis
☐ Blood Clots	☐ Heart Problems	☐ Multiple Sclerosis	☐ Ulcers
☐ Cancer	☐ Hepatitis	☐ Polio	☐ Weakness or Paralysis
☐ Frequent headache/Migraine			

Please mark any symptoms YOU are currently experiencing:

☐ Chest Pain	☐ Trouble Sleeping	☐ Dizzy Spells	☐ Constipation
☐ Wheezing	☐ Weight loss or gain	☐ Blurred vision	☐ Diarrhea
☐ Urinary frequency	☐ Fainting Spells	☐ Incontinence	☐ Double vision
☐ Shortness of breath	☐ Abdominal pain	☐ Nausea/vomiting	☐ Loss of appetite
☐ Vision Correction	☐ Fatigue	☐ Seizures	

The above information is completed to the best of my knowledge

Patient Signature:_____