ARROWHEAD PHYSICAL MEDICINE

First name: ____ **Last name**: ________________________________

Marital Status: **M S D**

Gender: **Male / Female** Birth Date: ___________________

Age:

Primary Address: ____

City: _State: ___________ Zip Code: _________

Secondary Address: ________________________________ City: ________ ST: Zip Code: _____________

Full time resident? **YES / NO** If Part-time, What months? _____________________________

Email Address: ____

Phone ( ) _____________________ Work ( ) _____________________ Cell ( ) _____________________

Working Status: **Employed** **Retired** **Student** **Self**

Occupation: ________________________________ Employer: _______________________________

Do you have Medical Insurance? **Yes / No** Company name: ______________________________

Emergency Contact person and Phone#:_____________________________ Relationship: ________________

How did you hear about us? ____

<u>WORK RELATED INJURY INFORMATION</u> _____________ **<u>PERSONAL INJURY INFORMATION</u>**

Is your injury work related? **YES / NO** Have you recently been involved in a motor vehicle accident? **YES / NO**

What is your main concern/ chief complaint? ____

Using a scale from 1-10 (10 being the worst) rate your pain? Please Circle 0 1 2 3 4 5 6 7 8 9 10
How long have you had this problem? ____

What other Doctors have you seen for this issue? Please Circle: Orthopedists Chiropractors Physician Other

Name of Doctor Clinic: ________________________________ Date of Service: __________________________

Name of Doctor Clinic: ________________________________ Date of Service: ___________________________
Other: ____

Have you had any x-rays, MRI's and/ or CT Scans taken from this complaint? **YES / NO** When? _________________
Body area: ______________________________________ Facility: ____

Have you attended prior Physical Therapy for this issue? **YES / NO** When? _____________ How long? _____________
Facility: ____

Have you taken any anti-inflammatory medication for this complaint {OTC or RX): **YES / NO**
What medication? _________________ How long? _________________________ Result ______________________
Have you ever taken pain medication for this complaint (Tylenol/Tramadol etc.): What medication? ________________
How long? ___________________________ Result: ____

CONTINUED ON BACK

What makes your pain worse? ____

What makes your pain better? ____

Have you experienced any of the following changes/ difficulties in your ability to perform: (PLEASE CHECK)

☐**Sitting** <10 min 10-25min >25min ☐**Standing** _____<10 min 10-25 mins >25 min

☐**Walking** <10min 10-25min >25min ☐**Lifting** _____, <10 min 10-25min >25 min

☐Bending ☐Kneeling ☐Fatigue ☐Poor Concentration ☐ Depression ☐Anxiety ☐Dizziness

Hobbies: ______________________________________ Sports/Exercise ______________________________

Sleep (Hours lost per night) ____

Review of Systems: (Please check those that apply)

Constitutional: ______________________

- o Chills
- o Fever
- o Weight Loss
- o Decline in Health
- o Weakness
- o Fatigue
- o Weight Gain

Head:

- o Dizziness
- o Headaches
- o Fainting
- o Pain
- o Head Injury
- o Sweats

Eyes:

- o Blurry vision
- o Eye Pain
- o Recent Injury
- o Discharge
- o Eyeglass Use
- o Unusual sensations
- o Double vision
- o Pain with Light

ENT:

Respiratory: ______________________

- o Asthma
- o Bronchitis
- o Pleurisy
- o Shortness of Breath
- o Cough
- o Positive TB test
- o Sputum
- o
- o Pain
- o Recent chest X-ray
- o Tuberculosis

Cardiovascular:

- o Chest Pain
- o Heart Murmur
- o Short of Breath- Exertion
- o Palpitations
- o High Blood Pressure
- o Short of Breath- Lying flat
- o Extremities Cool
- o History of Heart Attack
- o Thrombophlebitis

Gastrointestinal:

- o Abdominal Pain
- o Heartburn
- o Hepatitis
- o Constipation
- o Excessive Thirst
- o Vomiting

Skin:

- o Eczema
- o Hives
- o Itching
- o Lumps
- o Easy Bruising
- o Skin color change

Neurological:

- o Loss of consciousness
- o Dizziness
- o Headaches
- o Strokes
- o Blackouts
- o Fainting
- o Numbness
- o Tingling
- o Burning
- o Head Injury
- o Paralysis
- o Unsteady Gait

Endocrine:

- o Cold Intolerance
- o Heat Intolerance
- o Sweats

Hematological/Lymph:

- o Anemia
- o Blood Clots
- o Lumps

- O Discharge (nose)
- O Nasal Obstruction
- O Discharge (ears)
- O Pain (ears)
- O Hay Fever
- O Nosebleeds
- O Hearing Aids
- O Ringing in the ears

ALLERGIES: Please list all allergies and known reactions:

Food:

Medication:

Family History: Please list age of death, if deceased, of family member and circle which family member experienced the following:

Mother/Father- Arthritis at an early age

Mother/Father- Bleeding problems

Mother/Father – Cancer

Mother/Father- Congestive heart failure

Mother/Father- Diabetes

Mother/Father- Gout

Mother/Father- High blood pressure

Mother/Father- Scoliosis

Mother/Father- Tuberculosis

Past medical history: Have you been hospitalized in the last 5 years? ______________________________________

Explain: ____

Do you smoke tobacco? ☐ Never Smoked ☐ Former Smoker ☐ Current Smoker

If you currently smoke, please list how many cigarettes per day: ______________________________________

How often do you consume alcoholic beverages? ☐ Never ☐ Rarely ☐ Moderately ☐ Daily

List all surgeries you have had:

Date/Location/Why:

Date/Location/Why:

Date/Location/Why:

Date/Location/Why:

Please list all medications you are taking at this time (prescribed and over the counter). Also, please list all herbal products, homeopathic medications, supplements, vitamins, you are taking.

MEDICATION NAME:	DOSAGE (MG):	# PILLS PER DAY:	REASON FOR TAKING:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or staff members of Arrowhead Physical Medicine responsible for any omissions that I may have made in the completion of this form.

If you have any questions concerning this form or the above statements, please ask the doctor.

Patient Signature: ____ Date: ____________________