Name: _____ **Signature:** _____ **Date of Visit:** _____

Birthdate: _____ **Age:** ___ **Handedness** (*circle*): Right-hand. Left-hand. Ambidextrous.

Type of Athlete/Worker/Person(*write in*): _____

(e.g. Runner. / e.g. Plumber / e.g. Retired, Student)

Chief Complaint (i.e. *Reason for Visit*): _____

(2-3 words ... e.g. Left Knee Pain)

History of Present Illness / Symptoms: (Write few sentences telling the story when 1st started & describe)

_____

_____

_____

_____

_____.

Affect on Activities of Daily Living / Function (ADLs/IADLs): _____

REASON: Why did you choose to come in TODAY: _____

Pain Score Number/ Symptom level (*0* none – *10* bad): Current: ___ Best: ____ At Worst: ____

Character of Pain / Symptoms (*circle and/or write in*):

Ache. Dull. Throbbing. Sharp. Burning. Electric-like. Stabbing. Shooting. Deep. Tiring. Unbearable. Nagging. Tender. Tingling. Numbness. Other: _____

Initial Onset (*when did it 1st begin*): Date __/__/__ = ___ days, ___ months, ___ years ago

Onset Episodes (*circle and/or write in*): When you do the following motions below ...

bend, lift, walk, run, stairs, grip/grab, squat, kneel, over shoulder motion, sleep, other:

_____

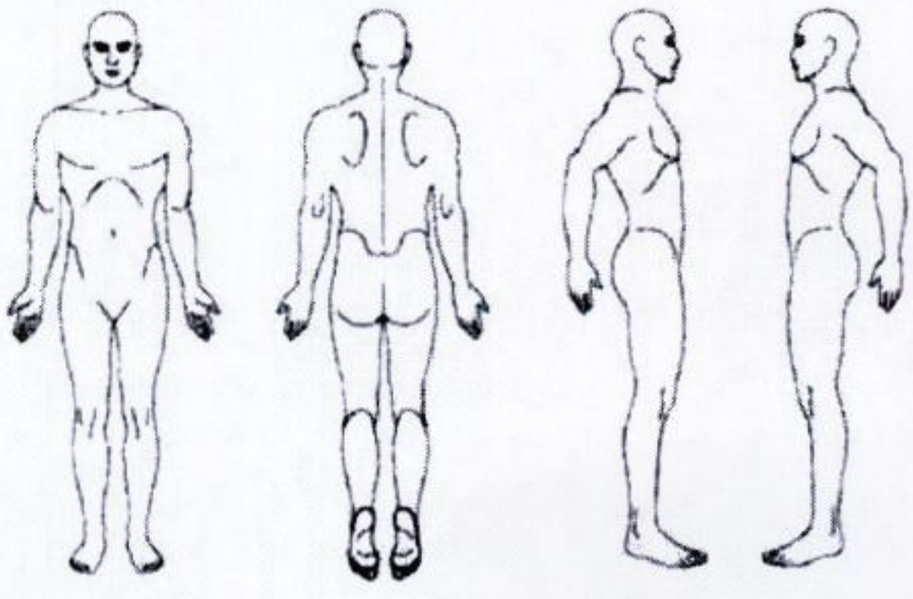
Frequency of Episodes (circle and/or write in): How often are the symptoms below ...

Always. All Day. All Night. Most mornings. Most afternoons. Most evenings. Most nights sleeping. Every few secs. Every few mins. Hourly. Every few hours. Few times daily. Few times weekly. Few times monthly. Few times yearly. Other:

_____

Location: _____

(*write in & mark body with X chart shown*)



Duration of Episodes (*circle*): *Lasting ..*

fleeting. few secs. few mins. few hrs.

few days. few wks. few mths. few yrs. Other

_____

Radiation of Symptoms (*circle/write in*)

to butt. to groin. down leg. below knee.

to toes. (L or R) down arm. to hand.

Other _____

Exacerbation what makes it worse (*circle/write in*): certain positions. over shoulder motion. bend. kneel. lift. throwing. squatting. other :_____
Alleviation what makes it better (*circle/write in*): rest. ice. heat. topical med. oral med (pills). other _____
Recurrence ever have these symptoms before? (*circle/write in*): Yes or No

Associated Symptoms you think might be related somehow (*circle/write in*): numbness. tingling. weakness. swelling. discoloration. Other: _____
Healthcare Providers seen already e.g. primary care doc, orthopedic, chiropractor (circle/write in): none. other: _____
Studies/Diagnostic Tests done already (*circle/write in*): none. Xrays. MRI. CT scan. EMG nerve test. Bloodwork. Other: _____
Treatment / Medications tried (*circle/write in*): none. Ice. heat. contrast therapy. topical med. oral med. home exercises. physical therapy. massage. acupuncture. Injection. rest. activity modification. electric stim. other bodywork. other: _____
Symptom Change Since Its Onset (*circle/write in*): SAME. BETTER. WORSE. Describe how?
_____

Additional Timeline of Symptoms: _____
_____
Other info/other symptoms: _____
_____
Past Medical History (*circle/write in*): migraines. headaches. Seizure. eye problems. hearing deficit. sinus condition. asthma. COPD. bronchitis. GERD. reflux. ulcer. Diabetes. thyroid disorder. hypertension/high blood pressure. heart disease/heart attack. stroke. mini-stroke. aneurysm. circulation issues. arthritis. rheumatologic/autoimmune condition. kidney problems. cancer. skin condition. mood condition. Other:_____
Medications (*circle/write in*): aspirin. blood thinner. vitamins. supplements.
Other (*Medication name only*): _____
_____
_____
_____
Allergies/Intolerances (*circle/write in*): aspirin. NSAIDS-ibuprofen. sulfa meds. Penicillin.
Other: _____
Surgical History (*write in include year*): _____
_____
Hospitalizations (*write in include year*): _____
_____
Family History (*circle/write in*): arthritis. other bone/joint condition. rheumatologic condition. Diabetes. asthma. neurologic condition. Other: _____
Social History (*circle/write in*): smoker married/single children ages ___ pets _____ hobby _____ occupation / company name _____exercise/activity _____
Review of Body Systems (*circle/write in*): appetite change. chills. fever. unexplained weight gain or loss.iltching. hives. change in vision. decreased hearing. runny nose. sore throat. feeling too hot. feeling too cold. cough. short of breath. chest pain. difficulty on exertion. irregular heartbeat. palpitations. abdominal pain. change in bowel habits. rectal bleeding. easy bruising. prolonged bleeding. change in urination. genital discharge or bleeding. Pregnant/possible pregnant. other joint symptoms. overly cold extremities. rash. headache. seizure. anxiety. depression. mental or physical abuse. learning disability. Other: _____