Name:

DOB: Age:

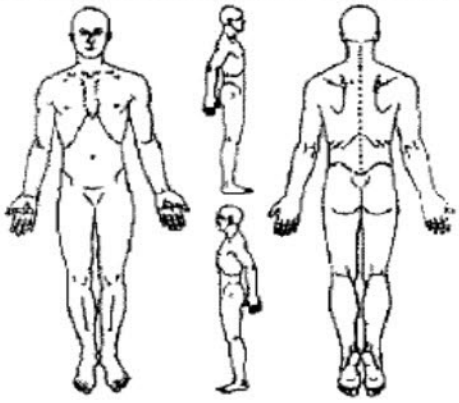
Chart: Date:

MEDICAL HISTORY

Who referred you to our office? _____ Who is your primary care physician? _____

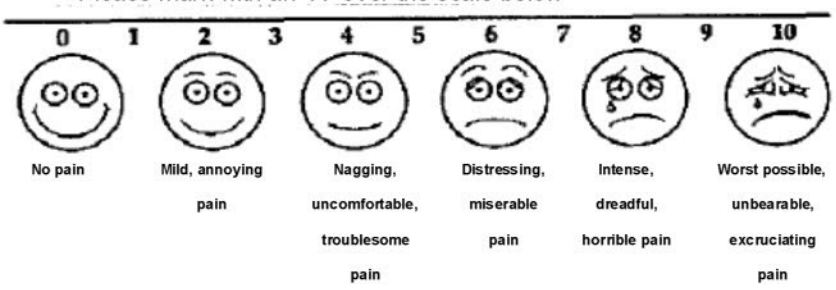
Are you: ☐ Right-handed ☐ Left-handed Height: _____ Weight: _____

CHIEF COMPLAINT: Put "X" over area(s) that hurt the most:



What is your level of pain today?

Please mark with an "X" over the scale below



Please describe your problem: _____

_____

Have you had treatment for this problem? (Please list medications, therapy, splints, etc):

_____

_____

MEDICAL HISTORY: Please list your medical conditions: (cancer, diabetes, hypertension, thyroid, ulcers, asthma, etc.):

1) _____ 3) _____ 5) _____

2) _____ 4) _____ 6) _____

SURGICAL HISTORY:

	Name of Procedure	Date	Surgeon
1)			
2)			
3)			
4)			

CURRENT MEDICATIONS (Including over-the-counter medications, vitamin supplements and herbal supplements:

(If you have a list, please give to us to photocopy) ☐ Taking No Medication

	Medication	Dosage	Frequency	Ordering Physician
1)				
2)				
3)				
4)				
5)				

Name:

DOB: Age:

Chart: Date:

ALLERGIES: ***Please list all allergies to medications, the type of reaction and the severity:*** ☐ No Drug Allergies

Medication	Reaction	Mild	Moderate	Severe	Unknown
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

Please list any allergies to non-medications, i.e., eggs, shellfish, latex, etc.:

SOCIAL HISTORY:

Martial Status: S / M / D / W If you have children, what are their ages? _____

What sporting activities / hobbies do you engage in? _____

Do you: drink alcohol? ☐ No ☐ Yes # of drinks per week _____ Street drugs Use? ☐ No ☐ Yes

SMOKING STATUS:

☐ Current every day smoker (Packs per day _____) ☐ Former smoker **Year Started_____/Quit_____**

☐ Current some day smoker (# of cigarettes _____) ☐ Unknown if ever smoked ☐ Never smoked

FAMILY HISTORY:

Does anyone in your family have a history of: (Use M for mother, F for father, B for brother, S for sister)

Heart disease _____ Cancer _____ Arthritis _____ Stroke _____ Back/Neck Problems _____

Rheumatologic _____ Anemia/bleeding problems_____ Hereditary Disease ____ If yes, what _____

WORK HISTORY:

Are you employed? ☐ No ☐ Yes Employer's Name: _____

Describe your job: _____

How long have you worked for them? _____ If you stopped working, when did you stop? _____

Is this a worker's compensation injury? ☐ Yes ☐ No If yes, employer at time of injury? _____

Are you represented by an attorney? ☐ Yes ☐ No If yes, name and city: _____

Please indicate below if you have had any difficulties in any of the following areas. Please answer each questions and briefly explain any "Yes answers.

	YES	NO		YES	NO
Weight loss ____ weight gain _____	☐	☐	Asthma	☐	☐
Trouble with eyes, ears, nose, throat	☐	☐	Recurring fevers	☐	☐
Loss of memory or concentration	☐	☐	Seizures / Strokes	☐	☐
Chest pains / Palpitations	☐	☐	Diabetes / Thyroid	☐	☐
Problems with your immune system	☐	☐	Frequent headaches	☐	☐
Difficulty breathing / Shortness of breath	☐	☐	Gallbladder / Liver	☐	☐
Abdominal pain / Cramping / Heartburn	☐	☐	Arthritic joints	☐	☐
Difficulty or burning with urination	☐	☐	Broken bones	☐	☐
New moles or skin problems	☐	☐	Mononucleosis	☐	☐
Difficulty with coordination	☐	☐	Increased drinking of fluids	☐	☐
Treatment by a psychiatrist	☐	☐	Increased need to urinate	☐	☐
Easy bruising or bleeding	☐	☐	Diarrhea / Constipation	☐	☐
Allergic reactions other than medicine	☐	☐	Stomach problems / Ulcers	☐	☐

Briefly explain any "YES" answers:

Patient/Guardian Signature: _____ Date: _____