PATIENT HISTORY FORM

Name:	**Date of Birth:**	**Height:**	**Weight:**

Referred By:	☐ Physician	☐ Self	☐ Family	☐ Friend	☐ Insurance Company	☐ Other

Name of Person/Physician Making Referral:

Reason for Your Visit:	Body Part:	☐Right ☐Left ☐Both
	☐ Acute, New Injury ☐ Old, Chronic Injury	

Approximate date symptoms began, or date of injury? :

Injury Resulted From: ☐ Sports ☐ Accident ☐ Work Related ☐ Other ☐ Unknown

How did your symptoms begin? If sudden, describe onset:

Have you seen another doctor in the last 6 months?

Check all that apply: ☐Pain ☐Stiffness ☐Swelling ☐Instability ☐Weakness ☐Numbness/Tingling

If you have pain, on a scale of 1-10 (10 being most severe), circle # that best describes your pain:	◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

What previous treatment have you had for this problem? (Medications, therapy, surgery, injection, none):

Are you: ☐ **Right Handed** ☐ **Left Handed**	**Occupation:**

PAST SURGICAL HISTORY/AND OR HOSPITALIZATIONS:

Type of operations or reason for hospitalization	Year
1.	
2.	
3.	

Any previous significant injuries or fractures? ☐ No ☐ Yes

Any history of anesthetic complications? ☐ No ☐ Yes

If yes, explain:

MEDICATION INFORMATION:

Drug Allergies: Do you have any drug allergies? ☐ No ☐ Yes

If yes, name the drug and the type of reaction: (rash, trouble breathing, nausea, etc.)

Current Medications: (List all meds including aspirin, vitamins, supplements, calcium, etc.)

Name of Drug	**Dose/Pills per day** (E.g. 500 mg 3 times/day)	**Name of Drug**	**Dose/Pills per day**
1.		5.	
2.		6.	
3.		7.	
4.		8.	

PATIENT HISTORY FORM

Medical History / Review of Systems			
GENERAL	✓	**CARDIOVASCULAR**	✓
Are you currently pregnant?		High cholesterol	
Diabetes		Heart Attack	
Reflux Disease		High Blood Pressure	
Stomach Ulcers		Stroke	
Cancer		Circulatory or Peripheral Vascular Disease	
If yes, What type of cancer?		**MUSCULOSKELETAL**	
Thyroid Problems		Rheumatoid or Inflammatory Arthritis	
Psoriasis		Osteoarthritis	
HIV/AIDS		Osteoporosis	
Hepatitis		Gout	
Tuberculosis		Bone/Joint Infections	
Blood Clots		Fractures or Dislocations	
Seizure Disorders		Stress Fractures	
Concussions		Ligament, Tendon or Joint Injury	
Dental Infections		**PSYCHOLOGICAL**	
Urinary Tract Infections		Depression	
Kidney Stones		Anxiety Disorder	
Prostate Enlargement		Eating Disorders	

Are you currently experiencing any of the following symptoms?

Fever, night sweats or chills		Wheezing		Skin changes, rash	
Unexpected weight loss		Nausea or vomiting		Unsteady gait	
Blurred vision or ringing in ears		Diarrhea or Constipation		Dizziness	
Headaches		Difficult urinating		Tremors	
Difficulty swallowing		Change in bowel habits		Nervousness	
Chest Pain or Palpitations		Blood in urine or stool		Heat / cold intolerance	
Shortness of breath		Swelling of multiple joints		Easy bleeding or bruising	

FAMILY HISTORY

Please indicate which family members (Mother, Father, Sibling, Grandparent) if any have a history of the following conditions:

Diabetes		Abnormal Bleeding Tendencies	
Cancer Type:		Rheumatoid arthritis	
Heart Disease		History of Anesthetic Complications	

Social History

Do you smoke?	No Yes Past	How much do (or did) you smoke?
Do you drink alcohol?	How many drinks per week?	Any history of substance abuse?
List all regular activities you are involved in: (e.g., jogging, basketball, weightlifting, yoga, etc.)		
1.	3.	5.
2.	4.	6.
I, as the patient , state the information is correct and accurate to the best of my knowledge: Signature :		Date: