Name: _____ Today's Date _____

DOB _____ Who Referred you to our office? _____

Please list why are you being seen by our office today: (Please included how long you have had this problem and what makes it worse)

_____

_____

Location of pain (include side): _____ How long ? _____

Describe Pain (Circle One): ☐ Dull ☐ Sharp ☐ Tingling ☐ Other: _____

When does the pain occur (Circle One)? ☐ At Rest ☐ With Activity ☐ At Night ☐ Other _____

Any other symptoms associated with current problem? _____

Severity on a scale from 1-10:
Indicate how severe the pain is on the scale below with 1=Little Pain and 10=Extreme pain

Circle One: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Indicate what makes it better (Circle One)? ☐ Pain Meds ☐ Ice ☐ Heat ☐ Rest ☐ Elevation

How did it occur? _____

If result of injury: Date Occur _____ Is it better? _____ Is it Worse? _____

Are you right hand or left hand dominant? _____

Please list your current medication: ☐ I have provided a written list of my medication.

Medication (including vitamins, supplements and Herbs)	Strength	How Often

Please list all major medical conditions you have or have experienced in the past.

Condition	Date (Month / Year)

Please list any know Allergies ☐ I have no known allergies

Allergy	Type of Reaction

Please list all previous surgeries with approximate dates

Surgery	Date (Month / Year)

Have you ever had general anesthesia? _____

Have you ever had any problems with anesthesia? _____

Please describe: _____

Please list any hospitalizations (other than surgeries) with approximate dates

Hospitalization	Date (Month / Year)

Family History: Are you adopted? ☐ Yes ☐ No

Family Member	Status A - Alive D - Deceased	Year of Birth	Age (Years)	Known Medical Condition or cause of death
MOTHER	☐A ☐D			
FATHER	☐A ☐D			
BROTHER / SISTER	☐A ☐D			
CHILD	☐A ☐D			

Social History:

Occupation: Marital Status:

Home (Circle): ☐ 1 Story ☐ 2 Story ☐ Entrance Steps ☐ Apartment ☐ Elevator

Do you exercise regular? ☐ Yes ☐ No Involved in school sports? ☐ Yes ☐ No

Do you use tobacco products? ☐ Y / N ☐ ☐ Former If Yes, what type, how often?

Alcohol Use: _____ Heavily ____ Moderately _____ Socially

_____ Occasionally _____ Rarely _____ Never

Review of Systems					
Do you have any of the following symptoms?					
Constitutional:	Yes	No	**Gastrointestinal:**		
Fatigue	_____	_____	Frequent Nausea &/or vomiting	_____	_____
Headaches	_____	_____	Diarrhea	_____	_____
Fever	_____	_____	Constipation	_____	_____
Weight Loss	_____	_____	Stomach Aches	_____	_____
HEENT			**Genitourinary:**		
Glasses	_____	_____	Frequent or painful urination	_____	_____
Double / Blurred vision	_____	_____	Blood in urine	_____	_____
Hearing Loss	_____	_____			
Jaw Discomfort	_____	_____	**Neuro / Psychiatric:**		
			Fainting or dizzy spells	_____	_____
Respiratory			Emotional Problems	_____	_____
Cough	_____	_____	Convulsions	_____	_____
Wheezing	_____	_____	Numbness / Tingling	_____	_____
Shortness of Breath	_____	_____			
			Musculoskeletal		
Cardiovascular			Joint Pain	_____	_____
Chest pain or pressure	_____	_____	Back Pain	_____	_____
Heart Palpitations/fluttering	_____	_____	Leg Pain	_____	_____
Heart Murmur	_____	_____	History of	_____	_____
Vascular			**Psychiatric**		
Leg cramps with walking			Change in mood /		
(Claudication)	_____	_____	Change in behavior	_____	_____
Change in color of hands or fee			Change in sleep pattern	_____	_____
(Raynaud's)	_____	_____			
Dermatologic (Skin)					
Rashes	_____	_____			
Skin Disorders	_____	_____			
Connective Tissue Disorder	_____	_____			
Hematology					
Easy bruising or bleeding	_____	_____			
Frequent nose bleeds	_____	_____			