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	______	______			