PATIENT INFORMATION		
Referring Physician	**Primary Care Physician**	
Name:	**Name:**	
Address:	**Address:**	
Phone:	**Phone:**	

REASON(s) you are here :____

On a scale of 0 – 10 (10 being the worst) how severe is your pain? (CIRCLE) 0 1 2 3 4 5 6 7 8 9 10

Height: _________ **Weight:** _______

Date of Injury: ________________

ACTIVE PROBLEM: Please describe your problem.

What body part is involved? ☐ Right ☐ Left (indicate body part) ______________________________________

How long ago did the problem begin? _______________

Where were you injured: ☐ No ☐ Auto ☐ Work ☐ Sports ☐ Home ☐ Other:__________

Quality of the pain is: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is: ☐ Constant ☐ Comes and goes (intermittent)

Do you have: ☐ Swelling ☐ Bruising ☐ Locking ☐ Catching ☐ Giving way weakness
☐ Numbness ☐ Tingling Weakness ☐ Loss of bowel or bladder function

What makes your symptoms better? ☐ Rest ☐ Elevation ☐ Ice/Heat ☐ Other:________

What makes your symptoms worse? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Lying down
☐ Kneeling ☐ Sitting ☐ Twisting ☐ Stairs ☐ Coughing

Since this problem started, it is: ☐ Getting better ☐ Getting Worse ☐ Unchanged

PAST MEDICAL HISTORY: Please place a checkmark (√) if you have had any of the following conditions:

Anemia (285.8,285.9)		Elevated Cholesterol (272.4)		Pancreatitis (577.9)	
Heart Attack/Acute MI (410.9)		Emphysema/COPD (492.8, 496)		Pulmonary Embolism (415.91)	
Asthma/Bronchitis (493.90,490)		Bleeding Ulcer-Esoph Ulcer w/hemorrhage (530.21)		Problems clotting, easy bruising, easy bleeding	
Atrial Fibrillation (427.31)		Epilepsy (345.90)		Psychiatric Disorder	
Bladder Infection/UTI (599.0)		Fractures :		Reflux (530.81)	
Bloody Stools-Red Blood in Bowel Movement (278.1)		Glaucoma (365.89)		Rheumatoid Arthritis (714.0)	
Cancer/Leukemia (199.1)		Gout (274.00)		Sleep Apnea (780.57)	
Cellulitis		Heart Arrhythmia/Sinus (427.9)		Stomach Ulcers/Gastric (531.90)	
Deep Venous Thrombosis of Lower Extremities (453.40)		Hepatitis (573.3)		Stroke (436)	
Coronary Artery Disease(414.00)		High Blood Pressure/Hypertension (401.9)		Thyroid Disorder (246.90,246.78)	
Diabetes Mellitus (250.00):		HIV		Osteoporosis (733.00)	
Dialysis or Kidney/Renal Disease (250.00, 593.9)		Liver Disease (569.9)		Other (Please explain):	
		Lyme Disease (088.81)			

(Adult Medical History cont. pg2)

PAST SURGICAL HISTORY/PROCEDURE: (Please list all surgical procedures and dates performed)

____

____

____

FAMILY HISTORY: Do any of your immediate family members have any of the following conditions?

☐ Heart Attack (AMI) ☐ Asthma ☐ Cancer ☐ Coronary Artery Disease ☐ Depression
☐ Diabetes ☐ Emphysema ☐ Glaucoma ☐ Lower Back Pain ☐ Neck Pain
☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Sickle Cell Anemia ☐ Thyroid Disorder
☐ Other:________

SOCIAL HISTORY

Are you currently working ? ☐ Yes ☐ No
Occupation:__________________________________ Employer: ____________________
Where do you live? ☐ Home ☐ Apartment ☐ Retirement Community ☐ Other ______________
Who do you live with :__________________________________
Do you use tobacco: ☐ Yes ☐ No ☐ Quit If Yes: ________ packs per day for _____ years.
Do you use alcohol: ☐ Never ☐ Occasional ☐ Daily ☐ Heavy ☐ History of Alcoholism
Any history of drug use: ____

ALLERGIES:

Are you allergic to any medications: ☐ Yes ☐ No If yes please list: ________________
Are you allergic to foods, metals or jewelry? ☐ Yes ☐ No If yes please list: ________________
Are you allergic to Latex? ☐ Yes ☐ No

MEDICATION HISTORY

Medication	Dose	How Often		Medication	Dose	How Often

TREATMENT Please check type of treatment you have received

☐	**Anti-inflammatory medications (ie Motrin, Aleve)**	☐	**Yes**	☐	**No**
☐	**Narcotic medication (ie Vicodin, Percocet)**	☐	**Yes**	☐	**No**
☐	**Brace/Cane/Crutch**	☐	**Yes**	☐	**No**
☐	**Physical Therapy or aspiration**	☐	**Yes**	☐	**No**
☐	**Have you seen an orthopedic surgeon for this problem?** **Orthopedist Name:**	☐	**Yes**	☐	**No**

(Adult Medical History cont. pg3)

List all surgeries, major illnesses, injuries, requiring hospitalizations

Date	Surgery/Major Illnesses, Injuries, and Hospitalizations	Hospital

DVT Assessment

Have you ever had a deep venous thrombosis or pulmonary embolism (DVT,PE)?		YES		NO
Has anyone in your family ever had a deep venous thrombosis or pulmonary embolism (DVT,PE)?		YES		NO
Do you currently have cancer?		YES		NO
Do you use oral contraceptives or take estrogen therapy?		YES		NO
Have you ever had bleeding ulcers or bloody stools?		YES		NO
Do you have problems with clotting, easy bruising, or easy bleeding?		YES		NO
Do you take Coumadin, Aspirin, Plavix or any other blood thinners?		YES		NO

(Adult Medical History cont. pg4)

Patient Name: **Acct #:**

Review of Systems: (Please check all that apply)

EYES	√	CARDIOVASCULAR	√	PSYCHOLOGIC	√
Glasses		Varicose Veins		Depression	
Cataracts		Rheumatic Fever		Anxiety	
Glaucoma		Heart Murmur		Bipolar Disorder	
Other:		Pulmonary Embolus		**Other:**	
SKIN		**Other:**		**GASTROINTESTINAL**	
Dermatitis		**ENDOCRINE**		Ulcers	
Rashes		Diabetes		Reflux	
Psoriasis		Thyroid Disease		Crohns	
Eczema		Other		Nausea	
Other:		**GENITOURINARY**		Vomiting	
EAR/NOSE/THROAT		Bladder Infection		Diarrhea	
Deafness		Kidney Disease		Constipation	
Allergies		Incontinence		Bloody/Black Bowel Mvmt	
Sinus Trouble		Kidney Infection		Abdominal Pain	
Nosebleeds		Kidney Stones		Liver Disease	
Chronic Sinus Infection		Frequent Urination		Jaundice	
Trouble Swallowing		Painful Urination		**Other:**	
Other		Bloody Urine		**CONSTITUTIONAL**	
NEUROLOGIC		Frequent Nighttime Urination		Fever	
Stroke		Prostate Problem		Weight Loss	
Seizures		**Other:**		Loss of Appetite	
Dizziness		**PULMONARY/RESPIRATORY**		Night Sweats	
Multiple Sclerosis		Asthma		Fatigue	
Numbness/Tingling		Emphysema		Chills	
Parkinson’s		Bronchitis		**Other:**	
Fainting		Pneumonia		**ONCOLOGIC**	
Blackouts/Falls		Wheezing		Cancer	
Other:		Shortness of Breath		Type	
INFECTIOUS DISEASE		Sleep Apnea		**MUSCULOSKELETAL**	
HIV		**Other**		Rheumatoid	
Hepatitis		**HEMATOLOGICAL/LYMPHATIC**		Osteoporosis	
Lyme Disease		Lymphedema		Joint Pain	
Positive TB test		Anemia		Back Pain	
Other:		Sickle Cell		Neck Pain	
HEART AND CARDIOVASCULAR		Easy Bleeding		Slipped Disc	
Chest Pain		Transfusion		Leg Pain	
Heart Attack		Abnormal Bruising		Joint Stiffness/Swelling	
Palpitations		Blood Disorder		Gout	
Heart Disease		**Other:**		**Other**	
Circulation problems				**OB / GYN**	
Blood Pressure? ▢ HI ▢ LOW				Pregnant Now? Y N	
Blood Clots				**Other:**	
Arrhythmia					