Last Name First Name Date of Birth Today's Date

Family Physician: _____Phone:_____
Address: Fax:

Briefly describe
Present symptoms: _____

_____

_____

How did injury occur or
Symptoms begin? _____

_____

_____

Date of injury or Present
Onset of symptoms _____Pain Level: __Low __Moderate__Severe

Please describe your pain:
(Circle all that apply) Burning Dull Throbbing Sharp Constant Other: _____

What makes your pain
Worse? _____

Have you ever had similar
Symptoms before?
Describe: (Yes/No) Explain:_____

As a result of this problem
Has there been any change Not employed Light Duty: (dates)_____
In your employment?
(please circle one) No Change Unable to work: (dates)_____

List X-rays, MRI, Scans, or_____
Other Special Studies
Performed (Location & Date):_____

List physician(s) that have
Treated you for these
Symptoms: _____

Did a health care provider
Recommend you see us?
(physician, physical
Therapist, athletic trainer) Yes No if yes, what is the name of the provider? _____

PATIENT NAME: **DOB:**

- o Ear infections
- o Eye infections
- o Hay fever /seasonal allergy
- o Pneumonia
- o Asthma/wheezing
- o Hypertension
- o Heart murmur
- o Atrial fibrillation
- o Phlebitis/varicose veins
- o Peptic ulcer
- o Hepatitis
- o Diverticulosis
- o Crohn's disease
- o Hemorrhoids
- o Hernia
- o Urinary tract infection
- o Kidney stone
- o Sexual transmitted disease.
- o Anemia
- o Cancer
- o Diabetes
- o Thyroid disease
- o Seizure disorder /convulsions
- o Stroke
- o Rheumatoid arthritis
- o Osteoporosis
- o Gout
- o Psoriasis
- o Eczema
- o Depression
- o Phobias
- o Mental illness
- o Tick bit
- o Lactose intolerance
- o Prostate disease
- o Sexual dysfunction
- o Menstrual dysfunction
- o Frequent infection
- o Diphtheria ▫chicken pox
- o Tetanus ▫polio ▫rubella
- o Measles ▫ mumps
- o Rheumatic fever
- o Scarlet fever
- o Tuberculosis
- o Herpes
- o Ringing in ears
- o Dizziness/fainting
- o Hair loss
- o Failing vision
- o Nosebleeds
- o Sinus trouble
- o Cough ▫fever ▫chills
- o Chest pain ▫shortness of breath
- o Swelling
- o Leg pain
- o Loss of appetite
- o Difficulty w/swallowing
- o Indigestion
- o /heartburn
- o Nausea
- o Vomiting
- o Diarrhea
- o Constipation
- o Change in bowel habits
- o Abdominal pain
- o Abdominal bloating
- o Bloody or tarry stools
- o Blood in urine
- o Loss of control urination
- o Painful urination
- o Urination overnight
- o Decrease in flow or force of urination
- o Chronic fatigue
- o Weight loss
- o Bruise easily
- o Tremor/shaking hands
- o Muscle weakness
- o Numbness/tingling
- o Back pain
- o Headaches
- o Rash ▫ eczema
- o Bone fracture/joint injury
- o Nervousness
- o Memory loss
- o Other
- o Other

FEMALES please complete

Pregnant? ▫yes ▫no
Planning ▫yes ▫no
Menstrual flow:
▫Regular ▫irreg. ▫pain
_____days of flow
_____length of cycle
Date of last period_____
▫ Pain/bleeding during or after sex
Number of:
__pregnancies__Abortions
__Miscarriages__Live births
Birth Control Method:
Name of pill_____
▫ Flushing/menopause
Date of last pap test_____
▫ Normal ▫ Abnormal
Date of last mammogram___
▫ Normal ▫ Abnormal

Medications/Vitamins/Supplements: **Allergies/Drug Allergies:** **Previous Surgeries:**

▫None_____ ▫None_____ ▫None_____

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY: (please circle)

Sleep Deficiency: Normal Restful Non-Restful Very Poor

Smoking: Occasional Moderate Heavy None **Quit:** ___yrs.___mos.

Alcohol Use: Occasional Moderate Heavy None

Substance Use: Occasional Moderate Heavy None

Exercise: Occasional Moderate Heavy None

FAMILY HISTORY: (please circle)

Heart Disease Cancer Diabetes Arthritis Osteoporosis

Loose Joints Migraine Asthma Allergy Other_____

Is there any other information you would like to provide?

_____

_____