Please take a minute to fill this out completely so we may provide you with the best care possible.

Patients Name____**Today's Date**_________________

DOB_____________**Age**___________**Race**______________ **Height**_____________**Weight**____________

Patient occupation: _________________________**Who referred you to our office?** ___________________

Body part you are being seen for today? __________________ **Right/Left** **Dominant Hand: R/L**

Was this an accident? ☐ **YES** ☐ **NO** **Date of Accident:** _________________

How did the accident occur:____

Have X-rays been taken? ________**MRI?**_________**CT Scan?**__________**Bone Scan?**_________

ALLERGIES TO MEDICATIONS: ☐ **I have no known allergies**

PAST MEDICAL HISTORY- **check all that apply. If none apply, please check here** ☐

☐AIDS/HIV
☐Alcoholism
☐Alzheimers
☐Anemia
☐Angina
☐Arthritis
☐ Asthma
☐Atrial fibrillation
☐Benign prostatic hypertrophy
☐Cancer:
☐Cerebrovascular Accident
☐ Other:___________________________

☐ Congestive heart failure
☐ COPD
☐ Coronary artery disease
☐ Crohn's disease
☐ Degenerative joint disease
☐ Depression
☐ Diabetes
☐ Drug abuse
☐ DVT(blood clot)
☐ Fibromyalgia
☐ Gallbladder disease

☐ GERD
☐ Gout
☐ Hepatitis
☐ Hyperlipidemia
☐ Hypertension
☐ Inflammatory bowel disease
☐ Juvenile rheumatoid arthritis
☐ Kidney disease
☐ Liver disease
☐ Lyme disease
☐ Migraine headaches

☐ Multiple sclerosis
☐ Myocardial infarction
☐ Obesity
☐ Osteoarthritis
☐ Osteoporosis
☐ Parkinson disease
☐ Peptic ulcer disease
☐ Psoriasis
☐ PVD
☐Renal disease
☐Rheumatoid arthritis

☐Scoliosis
☐Seizure disorder
☐Sleep apnea
☐SLE (Lupus)
☐Spinal stenosis
☐Spondyloarthropathy
☐Thyroid disease
☐Valvular disease

PAST SURGICAL HISTORY- **Check and list year of procedure.**

☐ ACL Surgery: ______________
☐ Angioplasty:_______________
☐ Angio w/ stent: _____________
☐ Appendectomy:_____________
☐ Arthroscopy ankle:__________
☐ Arthroscopy elbow:__________
☐ Arthroscopy hip_____________
☐ Arthroscopy knee: ___________
☐ Arthroscopy wrist:___________
☐ Arthroscopy shoulder:________

☐ Back surgery:________________
☐ CABG:_____________________
☐ Cardiac valve replacement:_____
☐ Carpal tunnel release:_________
☐ Cataract extraction:___________
☐ Cholecystectomy:_____________
☐ Colectomy: _________________
☐ Colostomy: _________________
☐ Discectomy: ________________
☐ Fracture Surgery:_____________

☐ Gastric bypass:_______________
☐ Hernia repair:________________
☐ Hip arthroplasty______________
☐ Hip replacement:_____________
☐ Knee replacement:____________
☐ Laminectomy: _______________
☐ LASIK: ____________________
☐ Meniscus surgery: ___________
☐ Muscle biopsy: ______________
☐ Pacemaker:__________________

☐ Small bowel resection:_______
☐ Thyroidectomy:____________
☐ Tonsillectomy:_____________
☐ Other: ____________________

Gender specific:
☐ Cesarean section: ____________
☐ Hysterectomy:________________
☐ Mastectomy:________________

IF YOU NEVER HAVE HAD SURGERY - PLEASE CHECK HERE ☐

MEDICATIONS: Please list below (Include birth control, herbals, dietary supplements, and over the counter medications)

☐ **I am not taking any at this time**

____

____

____

PLEASE FILL OUT REVERSE SIDE

REVIEW OF SYMPTOMS- Are you currently having any of the following- **Please check NO or YES**

Chills	☐ No	☐ Yes	Heart murmur	☐ No	☐ Yes	Paraesthesia	☐ No	☐ Yes
Fever	☐ No	☐ Yes	Abdominal pain	☐ No	☐ Yes	Seizures	☐ No	☐ Yes
Night sweats	☐ No	☐ Yes	Diarrhea	☐ No	☐ Yes	Tremors	☐ No	☐ Yes
Weight gain	☐ No	☐ Yes	Heartburn	☐ No	☐ Yes	Anxiety	☐ No	☐ Yes
Weight loss	☐ No	☐ Yes	Nausea	☐ No	☐ Yes	Depression	☐ No	☐ Yes
Blurred vision	☐ No	☐ Yes	Vomiting	☐ No	☐ Yes	Insomnia	☐ No	☐ Yes
Headache	☐ No	☐ Yes	Dysuria	☐ No	☐ Yes	Skin Infections	☐ No	☐ Yes
Hearing loss	☐ No	☐ Yes	Frequent urination	☐ No	☐ Yes	Skin lesion	☐ No	☐ Yes
Vertigo	☐ No	☐ Yes	Cold intolerant	☐ No	☐ Yes	Asthma	☐ No	☐ Yes
Cough	☐ No	☐ Yes	Heat intolerant	☐ No	☐ Yes	Food allergies	☐ No	☐ Yes
Chest pain	☐ No	☐ Yes	Memory loss	☐ No	☐ Yes	Seasonal allergies	☐ No	☐ Yes

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FAMILY HISTORY- Check all that apply- Put "**F**' for Father, "**M**" for Mother, "**G**" for Grandparent in the space provided.

ADD/ADHD	☐ No	☐ Yes ________	Gout	☐ No	☐ Yes________
Alcoholism	☐ No	☐ Yes ________	Hearing Impairment	☐ No	☐ Yes________
Allergies	☐ No	☐ Yes ________	Heart disease	☐ No	☐ Yes________
Alzheimer's disease	☐ No	☐ Yes________	Hodgkin's disease	☐ No	☐ Yes________
Anemia	☐ No	☐ Yes________	Hypertension	☐ No	☐ Yes ________
Asthma	☐ No	☐ Yes________	Kidney disease	☐ No	☐ Yes ________
Blood disease	☐ No	☐ Yes________	Learning disability	☐ No	☐ Yes ________
Cancer- bone	☐ No	☐ Yes________	Liver disease	☐ No	☐ Yes ________
Coronary artery disease	☐ No	☐ Yes________	Mental illness	☐ No	☐ Yes________
Cancer:	☐ No	☐ Yes________	Migraines	☐ No	☐ Yes________
Colitis	☐ No	☐ Yes________	Muscle disease	☐ No	☐ Yes________
Congenital heart disease	☐ No	☐ Yes________	Obesity	☐ No	☐ Yes________
COPD	☐ No	☐ Yes________	Osteoarthritis	☐ No	☐ Yes________
CVA(stroke)	☐ No	☐ Yes________	Osteoporosis	☐ No	☐ Yes________
Depression	☐ No	☐ Yes________	Parkinson's	☐ No	☐ Yes________
Developmental delay	☐ No	☐ Yes________	PVD	☐ No	☐ Yes________
Diabetes	☐ No	☐ Yes________	Renal disease	☐ No	☐ Yes________
Drug abuse	☐ No	☐ Yes________	Seizure disorder	☐ No	☐ Yes ________
Other:______________________________			Thyroid disorder	☐ No	☐ Yes________

OTHER HISTORY

Please describe your physical activity- (e.g. skiing, soccer, biking, yoga, etc.)

____

Tobacco/Alcohol Use:

Uses tobacco: ☐ Current ☐ Former ☐ Never

Do you Chew Tobacco or Smoke?_______________ # of Years__________________ Packs/Cans per week________

Year Quit__________________

Do you Drink: ☐ Yes ☐ No

Frequency:____________________ Amount:____________________

Have you ever had a substance abuse problem? ☐ Yes ☐ No

If yes, please specify:____