Today's Date: _____

In order to provide you with the best possible care, please complete all the information on this form.
This form is part of your medical record, so complete every line in all sections, then please sign the form.

(1) **PATIENT NAME:**_____ Date of Birth:_____ Age:_____

How are you referred to our practice?_____

(2) **CHIEF COMPLAINT:** Describe your current problem: _____

_____

When did this begin? _____

Do you have arm pain? (Yes / No)

Which side does it affect? (Left / Right / Both)

INJURY:

1. Did you have a specific injury? (Yes / No)
2. Date of injury: _____
3. Was this caused by car accident? (Yes / No)
4. Is it work related? (Yes / No)
5. Describe it briefly: _____
6. Mechanism of Injury (Seatbelt / Airbag / LOC)
7. Seat Type (Driver / Passenger)
8. Is your injury currently involved in legal action? (Yes / No)
9. Previous Injury (Yes / No)
10. Previous Surgery (Yes / No)

(3) **HPI:**

1. Pain description: [Sharp / Dull / Burning / Constant / Intermittent / Irradiation / Sudden / Worsening / Improving]
2. What makes it worse? [Work / Walking / Standing / Stairs/ Other: _____]
3. What makes it better? [Rest / Ice / Heat / NSAIDS / Tylenol / Narcotic / Cortisone Injection / Bracing / Cane / Crutches / Therapy]
4. Rate your pain on this scale: [(none) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (severe)]
5. What treatment was received [PT / Chiro / Acupuncture / Surgery / Injection] Any change in urinary urgency or frequency [Yes / No

(4) **MEDICAL HISTORY:** Mark any known problems below: **Height:**_____ **Weight:**_____

- **Neuro** TIA / Stroke Visual Problems Seizures
- **Endocrine** Thyroid (Hi/Low) Diabetes (Type 1 or 2) Obesity Cholesterol
- **Respiratory** Asthma COPD
- **Cardiac** Atrial Fibrillation Heart Attack High blood pressure
- **GI** GERD (reflux) Colitis
- **Vascular** Bleeding Problems Blood Cots Pulmonary Embolism Vascular Disease Anemia
- **Ortho** Osteoarthritis Rheumatoid Gout/Pseudogout Fibromyalgia Osteoporosis
- **Psych** Depression Anxiety Bipolar Disorder
- **Immune** Lupus HIV Hepatitis (A,B, or C)
- **Cancer** Type:_____ Surgery/Radiation/Chemotherapy:_____
- OTHER MEDICAL CONDITION:_____

(5) **SURGICAL HISTORY:** List ALL previous surgeries below:

Tonsils	Eye	Ear/Nose/Throat	Thyroid	Cosmetic	Pacemaker	Hernia
Breast	Lung	Heart (CABG)	Gallbladder	Vascular		
Appendectomy	Stomach/Bowel	Gastric Bypass	Prostate (TURP)	Hysterectomy		

Orthopedic:_____

Prior Spine Surgeries:_____

(6) **ALLERGIES:** List any Medication Allergies and your reaction(s):_____

Do you have a **Latex Allergy?** (Yes / No)

(7) **MEDICATIONS:** List all prescriptions & OTC meds (with dosages) and vitamins.

1)	5)	9)
2)	6)	10)
3)	7)	11)
4)	8)	12)

(8) **REVIEW of Systems:** Circle any current problems on each line below.

o **Constitutional:**	Fevers – Chills - Weight Loss - Fatigue	o **Skin:**	Itching - Rashes - Blisters - Ulcer
o **Eyes:**	Blindness - Blurriness - Cataracts	o **Musculoskeletal:**	Joint Pain - Swelling - Stiffnes
o **Ear/Nose/Throat:**	Hearing loss - Ringing - Nosebleeds	o **Neurologic:**	Dizziness – Numbness – Tingling - Tremor
o **Cardiovascular:**	Chest pain - Tightness - Palpitations	o **Psychiatric:**	Nervousness - Depression - Memory Los
o **Respiratory:**	Cough - Wheezing - Shortness of Breath	o **Endocrine:**	Excessive Thirst - Frequent Urinatio
o **Gastrointestinal**	Heartburn – Reflux – Rectal Bleeding	o **Hematologic:**	Easy Bruising - Excessive Bleedin
o **Genitourinary:**	Frequency - Urgency - Incontinence	o **Immunologic:**	Severe Allergy - Frequent Infection

(9) **LIST YOUR DOCTORS:**

Primary Care Physician:	**Other Medical Doctor:**	**Other Medical Doctor:**
Dr.	Dr.	Dr.

(10) **SOCIAL HISTORY:**

Your Current (or Former) Occupation:_____ **Employer:** _____

Current Work Status: (Full Duty - Light Duty - Sedentary - Not Working - Disabled - Retired)

If you are not working: When was the last time you worked?_____

- Marital Status: (Single – Married – Divorced – Widowed)
- Recreational Pursuits:_____
- Highest Level of Education:_____
- Do you **smoke**? (Yes / No) If yes, # packs / day? _____
- Do you consume **alcohol** on a regular basis? (Yes / No) If yes, # packs/ day?_____
- Do you take any narcotics (Yes / No) If yes, # packs/day?_____

(11) **FAMILY HISTORY:** List any known cancers, causes of death, immune diseases, bleeding disorders, or joint problems in your:

Parents:_____ **Siblings:**_____

PATIENT: The above information I have supplied is complete, true, and correct; to the best of my knowledge.

Patient Signature:_____ Date:_____

PROVIDER: I have reviewed and updated each section of this form with the patient.

Provider Signature:_____ Date:_____