Name:
DOB:
Chart:
Age:
Date:

New Patient or New Problem Visit Information

Reason for Today's Visit: _____
(which side? Right, left both) _____

When did the problem begin? _____ Date of Injury: _____

Was it related to an accident? ☐ Yes ☐ No

Please list anything that aggravates the problem: _____

_____

Type of pain: ☐ Ache ☐ Stabbing ☐ Throbbing ☐ Shooting ☐ Dull ☐ Click/Pop

Circle your pain levels *(0=no pain and 10=terrible pain)*

At worst	0	1	2	3	4	5	6	7	8	9	10
Today	0	1	2	3	4	5	6	7	8	9	10

Since the start of the problem, are you: ☐ Improving ☐ Getting Worse ☐ Staying the Same

Please list anything, including treatments, that help relieve the problem: _____

Whom have you seen for this problem? _____

What test(s) have been done? When? Where? X-Ray _____ MRI _____

CT Scan _____ Bone Scan _____ Other _____

What treatments have you had for this problem? _____

Medications: _____ Helped? ☐ Yes ☐ No ☐ Not Sure

Physical Therapy: Helped? ☐ Yes ☐ No When? _____ How many visits? _____

Injections (type/date) _____ Helped? ☐ Yes ☐ No ☐ Not Sure

Surgery (type/date) _____ Helped? ☐ Yes ☐ No ☐ Not Sure

Other _____ Helped? ☐ Yes ☐ No ☐ Not Sure

Have you ever had the same or similar problem before? ☐ Yes ☐ No ☐ Not Sure _____

Have you missed any work due to this injury? ☐ Yes ☐ No Last date worked? _____

Is this a Worker's Comp. injury? ☐ Yes ☐ No Is there an attorney involved? ☐ Yes ☐ No

Employer at the time of this injury: _____

How long have you worked for this company? _____ # of hours work(ed) per week _____

Current Employer: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Legal Guardian: _____ Date: _____

Office Use Only

Physician Reviewed:
Initials: _____ Date: _____

Name:
DOB:
Chart:
Age:
Date:

HEALTH HISTORY

Please complete the following information for review by your provider.

Height: _____ Weight: _____ Race: _____ Sex: _____ Dominant Hand: ☐ Right ☐ Left

Referring Doctor: _____ Family Doctor: _____ Occupation: _____

Patient Medical History

☐ Heart Trouble	☐ Gout	☐ Bleeding Problems	☐ Anemia	☐ AIDS/HIV
☐ High Blood Pressure	☐ Seizures	☐ Serious Injuries	☐ Stomach Ulcers	☐ Hepatitis
☐ Stroke	☐ Sleep Apnea	☐ Lung Disease	☐ Liver Trouble	☐ Other:
☐ Diabetes	☐ Kidney Trouble	☐ Asthma	☐ Thyroid Trouble	_____
☐ Arthritis	☐ Osteoporosis	☐ Phlebitis	☐ Cancer	_____

Previous Surgeries: ☐ None Hospital/Date

1.	4.
2.	5.
3.	6.

Family Medical History (Mark if any of these run in your family)

☐ Heart Trouble	☐ Stroke	☐ Arthritis	☐ Kidney Trouble	☐ Alcoholism
☐ High Blood Pressure	☐ Diabetes	☐ Gout	☐ Bleeding	☐ Cancer

Social History

☐ Married ☐ Single Do you live alone? ☐ Yes ☐ No If no, who do you live with? _____

# of children: _____ Do you exercise regularly? ☐ Yes ☐ No Describe: _____

Tobacco Use? ☐ Yes ☐ No Type: _____ Amount per day _____ # of years used: _____

Alcohol Consumption? ☐ Yes ☐ No Type/Amount/How Often: _____

Review of Systems *(recent or current conditions only)*

☐ Weight Change	☐ Ear Pain / Ringing	☐ Shortness of Breath	☐ Incontinence	☐ Numbness
☐ Fever/Chills	☐ Nosebleeds	☐ Cough	☐ Urinary Frequency	☐ Weakness
☐ Night Sweats	☐ Hoarseness	☐ Stomach Pain	☐ Urinary Burning	☐ Frequent Headaches
☐ Poor Appetite	☐ Difficulty Swallowing	☐ Nausea/Vomiting	☐ Irregular Periods	☐ Seizures
☐ Rash	☐ Tooth/Gum Trouble	☐ Frequent Diarrhea	☐ Vaginal Discharge	☐ Blackouts
☐ Insomnia	☐ Visual Changes	☐ Frequent Constipation	☐ Pregnant	☐ Chronic Infection
☐ Depression	☐ Chest Pain	☐ Blood in Stool	☐ Joint/Limb Swelling	☐ _____
☐ Anxiety	☐ Abnormal Heartbeat		☐ Joint Pain	
			☐ Lumps/Masses	
			☐ Backache	

Patient Signature: _____ Date: _____

Notes: _____

Physician Reviewed:
Initials: _____ Date: _____
Initials: _____ Date: _____
Initials: _____ Date: _____
Initials: _____ Date: _____

Name:
DOB:
Chart:
Age:
Date:

MEDICATION RECORD

Please complete the following information for review by your provider.

Allergies to Medications: ☐ **None** ☐ **Yes, list→**

Latex Allergy/Sensitivity? ☐ **Yes** ☐ **No**

Metal Allergy? ☐ **Yes** ☐ **No**

List any food allergies and reaction: ☐ *None*

Medication	Allergic Reaction

Medications you currently take (including over the counter medications, vitamins, herbs, & prescribed drugs):

☐ See separate medication list

Date	Medication	Dosage/Frequency	*For Surgery Center Use Only*

Provider Reviewed:

Initials: _____ Date: _____ Time: _____

Initials: _____ Date: _____ Time: _____

Initials: _____ Date: _____ Time: _____

Initials: _____ Date: _____ Time: _____