Date: ______________

Name:_______________________________ **Date of Birth:** __________

Address: ____

Street City State Zip

Cell Phone: ______________ Home Phone: ____________ Work Phone: ___________

Email: ________________________ Sex: ☐ M ☐ F Height: _____ Weight: ______

Occupation: ______________________ Employer's Name: ______________________

Emergency Contact (Name) ______________________ Phone: ____________ Relation to Patient: _________

Preferred Pharmacy (Name, Address): ____

Handedness (Mark one) ☐ Left-Handed ☐ Right-Handed ☐ Ambidextrous

Insurance Subscriber ID/Claim Number (Worker's Compensation Only)

Company/Plan Name: ___________ Subscriber ID #: ___________ Claim # (WorkComp only): ____________

Primary Care Physician Name: __________________________________ Phone:__________

Chief Complaint

Side: ☐ Left ☐ Right ☐ Both **Body Part:** ☐ Shoulder ☐ Knee ☐ Hip Other: ____________

Duration of symptoms: ____________ Pain rating (0-10): _______

Briefly describe origin of current problem and current symptoms: ___________________________

____

What makes your symptoms worse: ____

Recent Trauma history to the affected area? ☐ Yes ☐ No If yes, Injury date: ______________

Prior Injuries to the affected area? ☐ Yes ☐ No If yes, Prior Injury date: ______________

Description (If yes to above 2 questions): ____

Past Medical History: ☐ None

☐ Asthma	☐ GI ulcers	☐ Narcotic use (active)
☐ Autoimmune disorder	☐ Gout	☐ NIDDM.
☐ Bleeding disorder	☐ Hepatitis C	☐ Osteoarthritis
☐ Cancer	☐ HIV	☐ Osteoporosis
☐ Coronary artery disease	☐ Hypercholesterolemia	☐ PVOD
☐ Chronic pain	☐ Hypertension	☐ Renal disease
☐ Diverticulosis	☐ Hypothyroidism	☐ Rheumatoid arthritis
☐ Drug/Alcohol abuse	☐ IDDM	☐ Smoking
☐ DVT (Blood clots)/PE	☐ Kidney disease	☐ Steroid use
☐ Emphysema/Bronchitis	☐ Liver disease	☐ Other: ____________
☐ GERD	☐ Narcotic use (in the past)	

Past Surgical History: ☐ None

☐Cervical spine surgery
☐ Lumbar spine surgery
☐ Shoulder arthroscopy (Left)
☐ Shoulder arthroscopy (Right)
☐ Total Hip Arthroplasty (Left)
☐ Total Hip Arthroplasty (Right)
☐ Knee arthroscopy (Left)
☐ Knee arthroscopy (Right)
☐ Total Knee Arthroplasty (Left)
☐ Total Knee Arthroplasty (Right)
☐ Appendectomy
☐ Cholecystectomy
☐ Hysterectomy
☐ Partial colectomy
☐ Tonsillectomy
☐ Vasectomy
☐ Wisdom teeth extraction
☐ Other: ___________________

Family History (Family members with a history of blood clots (DVT), pulmonary embolism (PE), cancer, heart attack, stroke, autoimmune disease, or other serious medical condition): ☐ None

____

Social History:

Smoke/Use tobacco: ☐ Yes ☐ No If yes, packs/day: _____ Number of years smoking: ______

Drink alcohol: ☐ Yes ☐ No If yes, how much/how often: ____________________________

Street drugs: ☐ Yes ☐ No If yes, which drugs, how much, and how often: ____________________

Allergies: ☐ None ☐ Penicillin ☐ Latex ☐ Other: ____

____

Medications (Name, dose, frequency): ☐ None

____

____

Treatment: ☐ None If yes to prior treatment, list details below.

☐ Physical Therapy (Name/Location/# sessions attended): ____

☐ Injections (Steroid, Gel, PRP. Date/Type of Injection/Outcome): _____________________________________

☐ Imaging (X Rays, MRI, CT, Nerve Conduction. Date/Imaging center name): _________________________

☐ ER Visit (Date/Hospital name/Treatment): ____

☐ Urgent Care Visit (Date/Facility name/Treatment): ____

☐ Splinting/Bracing (Date/Duration of use): ____

☐ Treatment by Another Physician (Date/Name/Treatment): ____

☐ Assistive Devices (Cane, Scooter, Walker. Frequency):____