



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, Autoimmune Disorder, Bleeding Disorder, Cancer, Coronary Artery Disease, Chronic Pain, Diverticulosis, Drug/Alcohol Abuse, Blood Clots (DVT/PE), Emphysema/Bronchitis, Gastric Reflex (GERD), GI Ulcers, Gout, Hepatitis C, HIV, High Cholesterol (Hyperlipidemia), High Blood Pressure (Hypertension), Underactive Thyroid(Hypothyroidism), Insulin-Dependent Diabetes (IDDM), Kidney Disease, Liver Disease, Narcotic Use (In the past), Narcotic Use (Active), Non-Insulin Dependent Diabetes (NIDDM), Osteoarthritis, Osteoporosis, PVOD, Renal Disease, Rheumatoid Arthritis, Smoking, Steroid Use, Other

Past Surgical History: None

- | | | |
|---|--|--|
| <input type="checkbox"/> Cervical spine surgery | <input type="checkbox"/> Knee arthroscopy (Left) | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Lumbar spine surgery | <input type="checkbox"/> Knee arthroscopy (Right) | <input type="checkbox"/> Partial colectomy |
| <input type="checkbox"/> Shoulder arthroscopy (Left) | <input type="checkbox"/> Total Knee Arthroplasty (Left) | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Shoulder arthroscopy (Right) | <input type="checkbox"/> Total Knee Arthroplasty (Right) | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Total Hip Arthroplasty (Left) | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Wisdom teeth extraction |
| <input type="checkbox"/> Total Hip Arthroplasty (Right) | <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> 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): _____