

NEW PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Occupation: _____ **Who referred you to our office/ PCP:** _____

What are we seeing you for today? _____

Side: ☐ LEFT ☐ RIGHT ☐ BOTH

When did your symptoms start (date)? _____

What are your expectations today? Explanation or diagnosis Tests Medication Therapy Injection Surgery

Please check ONE box that best describes how your problem started:

No Injury- Onset was: ☐ Gradual ☐ Sudden **Why do you think it started?** _____

Injury: ☐ Accident ☐ Sport ☐ Work related ☐ Worker's compensation ☐ Motor Vehicle Accident

Date of injury? _____ Sport? _____ School? _____

On a scale of 0-10 (0 is no pain, 10 is the worst) how would you rate your pain? (Circle) 0 1 2 3 4 5 6 7 8 9 10

Pain frequency: Constant Intermittent Occasional Rare

Since your problem started, it is: Getting better Getting worse Unchanged

Quality of pain: Aching Burning Dull Sharp Throbbing Other: _____

What makes your symptoms worse? Bending Climbing Stairs Descending stairs Sitting Standing Lifting Movement
Pushing Walking Other: _____

What makes your symptoms better? Brace/Splint Elevation Exercise Heat Ice Injection Massage OTC/ Rx Meds
Therapy Rest Stretching Other: _____

Associated symptoms: Bruising Crepitus Decreased mobility Instability Limping Locking Numbness Popping
Spasms Swelling Tingling Weakness Nocturnal awakening

What was your most recent height: ____/____ **Weight?** _____

Medications (Please list all vitamins, supplements, and over the counter meds as well as prescription drugs):

Allergies (Please list what type of reaction you had in addition to the name of the drug):

Please list any previous surgeries and what year you had them: _____

Marital Status: Single Married Separated Divorced Widowed **Smoking status:** Never Quit – what year? _____

Smoker- How many per day? _____ **Do you consume caffeine?** Never Yes- What type? _____

Alcohol use: Never Rarely Moderate Daily **Drug use:** Never Yes- Type & Frequency? _____

Medical History- Please check all that apply and list yourself and family members to which this applies on the line provided. Please also include Maternal (M) or Paternal (P) where applicable.

- ☐ High blood pressure _____ ☐ Heart disease _____
- ☐ Bleeding Problems or blood clots _____ ☐ Stroke _____
- ☐ Thyroid disease _____ ☐ Respiratory problems _____
- ☐ Diabetes _____ ☐ Cancer (What type?) _____

Review of Systems- Please circle all that apply to you.

Constitutional: Good General Health Recent weight gain Recent weight loss Night sweats Fevers Fatigue

Cardiovascular: Chest pain Palpitations Heart Murmur Leg Swelling

Endocrine: Cold intolerant Heat intolerant Hair loss

Ear/Nose/Throat/Mouth: Hearing loss Ringing in ears Vertigo Headaches

Eyes: Wear glasses Contacts Blurred vision Double vision Vision loss

Respiratory: Shortness of breath Wheezing Cough Known tuberculosis exposure

Neurological: Memory loss Paralysis Tremors Convulsions Seizures Difficulty walking

Hematologic/ Lymphatic: Bruise easily Bleeding Slow to heal

Psychiatric: Depression Anxiety Insomnia

Gastrointestinal: Nausea Vomiting Abdominal pain Loss of appetite Diarrhea

Genitourinary: Frequent urination Blood in urine Incontinence

Integumentary (Skin): Lesion Rashes Itching Infection Contact allergy

Allergic/ Immunologic: Food allergies Environmental allergies Seasonal Allergies Bee sting allergies Asthma

Patient statement: To the best of my knowledge, the above information is accurate.

Patient signature: _____ **Date:** _____

Provider signature: _____ **Date:** _____