

NEW PATIENT/INJURY MEDICAL FORM

Name: _____ Date: _____ Birthdate: _____

Occupation: _____ Who referred you to us? _____

Please explain your problem in one sentence _____

Location of symptoms **Left * Right * Both**

Onset of Symptoms _____

What are your expectations today? **Explanation or Diagnosis * Tests * Medicines * Therapy * Injection * Surgery**

Check the **ONE** box that best describes how your problem started:

NO INJURY- onset was **___ Gradual ___ Sudden** Why do you think it started? _____

INJURY- **___ Accident ___ Sport** Date of injury _____ Sport? _____ School? _____

WORK RELATED Date of Injury/Pain _____ How? _____

AUTO ACCIDENT Date _____

On a scale of 0-10 (10 is the worst) how severe is your pain? (Circle) 0 1 2 3 4 5 6 7 8 9 10

Pain Frequency : **Constant * Intermittent * Occasional * Rare**

Quality of Pain : **Aching * Burning * Dull * Piercing * Sharp * Throbbing * Other** _____

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

What make your symptoms worse? **Bending * Climbing Stairs * Descending Stairs * Sitting * Standing * Lifting * Movement Pushing * Walking * Other** _____

Pain is relieved by : **Brace/Splint * Elevation * Exercise * Heat * Ice * Injection * Massage * OTC * Meds * PT * Rest * Stretching Nothing *Other** _____

Associated Symptoms: **Bruising * Crepitus * Decreased Mobility * Instability * Limping * Locking * Numbing *Popping * Spasms Swelling * Tingling * Weakness * Nocturnal Awakening * Other** _____

MEDICAL HISTORY: Please check if **you** have any of the following:

High blood pressure

Diabetes

Stroke

Heart disease

Cancer

Respiratory Problems

Bleeding problems

Drug Allergies

(List) _____

Current Medications: _____

Past hospitalizations/surgeries/injuries and approximate dates: _____

Please check if any of your relatives ever had any of the following problems- indicate who:

Heart disease Who: _____ High blood pressure Who: _____

Diabetes Who: _____ Stroke Who: _____

Cancer Who: _____ Thyroid disease Who: _____

SOCIAL HISTORY:

Marital status: single married separated divorced/widowed
Tobacco use: never quit-when _____ smoker/pack per day _____
Alcohol use: never rarely moderate daily
Drug use: never type and frequency _____

Height _____ / _____ *Weight* _____

REVIEW OF SYSTEMS (Check all that apply to you)**Constitutional**

Good General Health
Recent weight loss/gain
Night sweats, fevers
Fatigue

Ears/Nose/Mouth/Throat

Hearing loss or ringing
Sinus problems
Vertigo
Headaches

Eyes

Wear glasses/contacts
Blurred/double vision
Vision Loss

Cardiovascular

Chest pain
Palpitations
Heart Murmur
Swelling Legs

Respiratory

Shortness of breath
Cough
Wheezing/asthma
Know TB Exposure

Gastrointestinal

Nausea/vomiting
Abdominal Pain
Loss of Appetite
Diarrhea

Musculoskeletal

Muscle pain or cramps
Stiffness/swelling in joints
Joint pain
Trouble walking

Neurological

Memory Loss
Paralysis or tremors
Convulsions/seizures
Difficulty Walking

Integumentary (Skin)

Lesion
Rashes or itching
Infection

Endocrine

Cold Intolerant
Hair Loss
Heat Intolerant

Hematologic/Lymphatic

Bruise easily
Slow to heal
Bleeding

Allergic/Immunologic

Food allergies
Aspirin allergies
Antibiotic allergies

Psychiatric

Depression
Insomnia
Anxiety

Genitourinary

Frequent Urination
Blood in Urine
Incontinence

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

Signed: _____ Date: _____