

PATIENT INFORMATION

DATE: _____

Name: _____ DOB: _____ Sex: **M** **F**

Race: _____ Age: _____ Family MD: _____

Involved body part: _____ Referring MD: _____

Date of injury / onset: _____ Work related: **YES** **NO**

Last full-time work date: _____ Do you need a form to return to work/school: **YES** **NO**

How injury occurred? : _____

Where injury occurred? : _____

Dominant Hand? (circle one): **LEFT-HANDED** **RIGHT-HANDED**

CHIEF COMPLAINT / HPI: (the reason for today's visit):

Location (Example bottom of foot, left hand, etc): _____

Quality (Example: throbbing, numb, etc): _____

Severity (Example: intolerable, dull, sharp, etc): _____

Duration (Example: all day, few minutes, all night, etc): _____

Timing (Example: upon rising, at end of day, etc): _____

Context (Example: while typing, after exercising, etc): _____

Modifying Factors (Example: what improves or worsens symptoms, etc): _____

Associated Signs & Symptoms (Example: tingling, stiffness, etc): _____

KNOWN SIGNIFICANT MEDICAL DIAGNOSES AND CONDITIONS:

Height: _____ Weight: _____

Medical Illnesses: (Please check below all that apply)

- | | | | |
|---|------------------------------------|--|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Depression | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Severe Anxiety | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Allergies/ Hay Fever | <input type="checkbox"/> Gout | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Malignancies |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Anemia | <input type="checkbox"/> Skin Disorders | |

Other health complications not listed above: _____

PAST MEDICAL HISTORY:

Known significant medical operative and invasive procedures (*type of surgery and date*):

Family Medical History (*list family illnesses*):

SOCIAL HISTORY:

Do you work outside the home? YES NO If yes, occupation? _____

What physical activities do you do on a regular basis? : _____

Do you smoke? YES NO If yes, how much and how long? _____

Do you consume alcohol? YES NO If yes, how much and how long? _____

ADVERSE AND ALLERGIC DRUG REACTIONS (*list all*):

MEDICATIONS CURRENTLY TAKING (*list all*):

OTHER: Are there other questions or concerns that you have for your Doctor/ provider today? If so, please list them below:

Are you a resident of a skilled nursing facility? YES NO

If yes, name of facility? _____

Address _____

Effective Dates From: _____ *TO:* _____

PATIENT / GUARDIAN SIGNATURE

DATE