New Patient History Form

Name:_____ Age: ____ D.O.B.: __/__/____ Occupation:_____

Date: __/__/____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D Weight: _____

Reason for today's visit: _____

_____

Is your problem work related? ☐ Y ☐ N

Current Medications: _____

_____

_____

Medical Allergies:_____

Past Medical and Surgical History: **Check the appropriate boxes**

☐ AIDS/HIV	☐ Coronary Artery Disease	☐ High Blood Pressure	☐ Stomach ulcers
☐ Alcoholism	☐ Crohn's disease	☐ Inflammatory Bowel	☐ Psoriasis
☐ Alzheimer's	☐ Degenerative arthritis	☐ J. Rheumatoid Arthritis	☐ Vascular disease
☐ Low blood count	☐ Depression	☐ Kidney disease	☐ Renal disease
☐ Chest pain	☐ Diabetes	☐ Liver disease	☐ Rheumatoid Arthritis
☐ Arthritis	☐ Drug abuse	☐ Lyme disease	☐ Scoliosis
☐ Asthma	☐ Blood clot	☐ Migraines	☐ Seizures
☐ A Fib (heart rate irregular)	☐ Fibromyalgia	☐ Multiple Sclerosis	☐ Sleep Apnea
☐ Enlarged prostate	☐ Gallbladder disease	☐ Heart Attack	☐ Lupus
☐ Cancer	☐ Esophageal reflux	☐ Obesity	☐ Spinal Stenosis
☐ Stroke	☐ Gout	☐ Osteoarthritis	☐ Back Arthritis
☐ Heart failure	☐ Hepatitis	☐ Osteoporosis	☐ Thyroid disease
☐ emphysema	☐ High cholesterol	☐ Parkinson's disease	☐ Heart Valve disease
☐ ACL surgery	☐ Back surgery	☐ Hernia repair	☐ Rotator Cuff surgery
☐ Angioplasty	☐ Heart bypass surgery	☐ Hip surgery	☐ Bowel resection
☐ Heart stents	☐ Heart valve surgery	☐ Hip replacement	☐ Thyroid surgery
☐ Appendectomy	☐ Carpal Tunnel surgery	☐ Knee replacement	☐ Tonsillectomy
☐ Ankle Arthroscopy	☐ Cataract surgery	☐ Laminectomy	☐ C-section
☐ Elbow Arthroscopy	☐ Gallbladder surgery	☐ LASIK	☐ Hysterectomy
☐ Hip Arthroscopy	☐ Colon resection	☐ Meniscus surgery	☐ Breast surgery
☐ Knee Arthroscopy	☐ Colostomy	☐ Muscle Biopsy	☐ Prostate surgery
☐ Wrist Arthroscopy	☐ Disk removal	☐ Broken bone fixation	☐
☐ Shoulder Arthroscopy	☐ Gastric bypass	☐ Pacemaker	☐

Other Past Medical or Surgical History:_____

_____

Review of Systems: **Please check all appropriate boxes**

Constitutional: ☐ fever ☐ fatigue ☐ night sweats

HEENT: ☐ vision changes ☐ headaches ☐ hearing loss

Respiratory: ☐ cough ☐ wheeze ☐ irregular breathing ☐ shortness of breath

Cardiovascular: ☐ chest pain ☐ irregular heart beat

Gastrointestinal: ☐ vomiting ☐ diarrhea ☐ constipation ☐ abdominal pain

Genitourinary: ☐ pain with urination ☐ blood in the urine

Metabolic/Endocrine: ☐ frequent urination ☐ frequent thirst or hunger ☐ cold or heat intolerance

Neuro/Psychiatric: ☐ dizziness ☐ emotional disturbances

Musculoskeletal: ☐ bone/joint pain ☐ bone/joint swelling ☐ weakness

Hematology: ☐ bruising ☐ bleeding.

Immunology: ☐ food allergies ☐ environmental allergies

Social History

Hand Dominance: ☐ Left ☐ Right **Exercise level:** ☐ Sedentary ☐ Moderate ☐ Vigorous

Exercise Frequency: ☐ Daily ☐ 3-4 times per week ☐ 2-3 times per week ☐ occasionally ☐ never

Do you smoke? ☐ Y ☐ N **If yes, how many packs per day?**_____ **For how many years?**_____

How many drinks with alcohol would you have in a typical week?_____

Family History

If one of your family members had or has a condition listed below, mark the box in the appropriate column

☐ ADD/ADHD	☐ Gout
☐ Alcoholism	☐ Hearing loss
☐ Allergies	☐ Heart disease
☐ Alzheimer's	☐ Hodgkin's disease
☐ Anemia	☐ High blood pressure
☐ Asthma	☐ Kidney disease
☐ Blood Disease or bleeding problems	☐ Learning disorder
☐ Bone Cancer	☐ Liver disease
☐ Heart Artery Disease	☐ Mental Illness
☐ Cancer	☐ Migraines
☐ Colitis	☐ Muscle disease
☐ Heart Failure	☐ Obesity
☐ Heart Defects	☐ Arthritis
☐ Emphysema	☐ Osteoporosis
☐ Stroke	☐ Parkinson's
☐ Depression	☐ Vascular disease
☐ Developmental Delay	☐ Renal disease
☐ Diabetes	☐ Seizure disorder
☐ Drug Abuse	☐ Thyroid disease
☐ Mental Delay	☐ Anesthesia problems

Your Current Problem

Name:_____ **DOB:**_____

Body Part: _____

Left or **Right**

Did you have an injury? Yes No If yes; when? ____/____/____
How did the Injury Occur:_____

If the problem is not from an injury, when did the pain start? _____

How frequently does the pain occur? □ Intermittently □ Occasionally □ Persistently

On a scale of 1 to 10, how severe is the pain? _____

Does the pain travel? □ Yes □ No Where?_____

How would you describe the pain? □ Aching □ Piercing □ Burning
□Dull □ Throbbing □ Sharp

Check the appropriate box if you are experiencing any of these symptoms:

□ Bruising	□ Locking	□ Swelling	□ Crunching Noise
□ Tingling in Arms	□ Weakness	□ Spasms	□ Decreased Motion
□ Numbness	□ Tingling in legs	□ Limping	□ Night Time Awakening
□ Tenderness	□ Instability	□ Popping	□ Difficulty falling asleep

□ Other:_____

Check the appropriate box if your problem is made worse by any of the following:

□ Bending	□ Lifting	□ Sitting	□ Daily Activities
□ Climbing Stairs	□ Movement	□ Standing	□ Descending Stairs
□ Pushing	□ Walking	□ Other: _____	

Check the appropriate box if your problem is made better by any of the following:

□ Brace/Splint	□ Ice	□ Prescription Meds	□ Physical Therapy
□ Elevation	□ Injection	□ Mobility	□ Rest
□ Exercise	□ Massage	□Stretching	□ Over the counter Meds
□ Heat	□Other:_____		