New Patient Form

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Name: _____ Birthdate: _____Gender: ___M__F

Today's Date: _____Date of Injury: _____Are you? __ Right-handed __Left-handed

Primary Care Physician: _____

Height: _____ Weight: _____ lbs (pounds) **Age: _____**

Is This Injury Work Related? ___Yes ___ No **If yes, was it reported ?** ___Yes ___No

Were you sent to our office by a physician? _____ Yes _____ No

If yes, physician's name? _____

What brought you here today/ Chief Complaint? _____

Location: _____ Quality: _____
Where is the pain? Does it travel to other areas ? *What does it feel like?e.g. Sharp/ Dull/ Throbbing*

Severity: _____ Duration: _____
(0-10) scale with 10 being the worst *How long have you had this problem?*

Timing: _____Context: _____
When does the pain/problem occur? *What were you doing when the pain/problem started?*

Associated signs/symptoms: _____
What associated problems are you having, if any? Such as numbness, stiffness, clicking, night pain, instability

Modifying factors: _____
What makes the problem/pain better ? What makes it worse?

Have you seen any other physicians regarding *this* condition prior to coming to this office?
Doctor When Tests Results Treatment

Have you ever experienced any injury or symptoms regarding this body part in the past?
__Yes __No

If yes, please provide details: _____

Past Medical History:

__ AIDS/HIV	__ Diabetes	__ Mitral Valve Prolapse or other Heart Valve Problems
__ Anemia	__ Glaucoma	__ MRSA Infection
__ Asthma	__ Heart Disease	__ Pneumonia
__ Bladder Infections	__ Hepatitis/ Liver Disease	__ Seizures
__ Bleeding Tendency	__ High Blood Pressure	__ Sleep Apnea
__ Blood Transfusions	__ Kidney Disease	__ Stroke
__ Bronchitis or COPD	__ Low Blood Pressure	__ Thyroid Disease
__ Cancer	__ Migraines	__Ulcer/ Stomach problems

Other problems not mentioned above: _____

Have you or anyone in your family ever had a DVT (blood clot) or PE (pulmonary embolus, blood clot in the lung)? ___ Yes ___ No

Past Surgical History:

Date Surgery Doctor

Date Surgery Doctor

Medications: (include non-prescription and herbal supplements)

Allergies: (Include medication name and reaction)

Social History:

Occupation: _____

Marital Status: __Single __ Married __ Divorced __ Widowed __ Separated

Use of Alcohol: __ Never __ Rarely __ Socially __ Daily

How often/ how much? _____

Use of Tobacco: ___Never
___ Previous, but quit. If yes, when did you quit and how many packs & years did you smoke? _____
___ Currently. If yes, how many pack per day? _____

Please list any hobbies or sports you enjoy: _____

Family Medical History: *Are there any medical problems that run in your family?*

Review of Systems:

Do you have pain in any other joint? ___ Yes ___ No If yes, which joint(s)? _____

Do you have any numbness or tingling in the affected extremity? ___ Yes ___ No