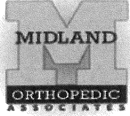

Medical History

Name:_______________________________ Age:______________ Birthdate:___/___/_____

Height:__________ Weight: __________ ***Family Physician (PCP):*__________________________**

Employer:____

Occupation:____

Who referred you to us? ____

You are: ☐ ***right-handed*** ☐ ***left-handed***

What body part is involved?				
Neck ☐	**Shoulder** ☐R ☐L	**Elbow** ☐R ☐L	**Hip** ☐R ☐L	**Lower Leg** ☐R ☐L
Back ☐mid ☐low	**Upper Arm** ☐R ☐L	**Wrist** ☐R ☐L	**Knee** ☐R ☐L	**Ankle** ☐R ☐L
	Forearm ☐R ☐L	**Hand** ☐R ☐L	**Upper Leg** ☐R ☐L	**Foot** ☐R ☐L

Is your current problem related to an injury? ☐ Yes ☐ No Date of Injury: _______

Cause of Injury: ☐ Work Accident ☐ Car Accident ☐ Home Accident
☐ Sports Activity ☐ School Activity ☐ Other:____________________

How did you injure yourself? ____

Did you report it to anyone? Yes ( ) No ( )

If your current condition is not related to an injury, how long has it bothered you? _______________

What gives your symptoms relief? ____

What aggravates your symptom? ____

What tests did you have? XRAY ( ) MRI ( ) EMG ( ) NONE ( ) other ________________________

What treatment have you had? Medication ( ) Surgery ( ) Therapy ( ) Injections ( ) None ( ) Other (Explain)

____

If prior treatment was received who was the treating physician? ____________________________

Have you ever had surgery? ☐ NO ☐ YES If yes what type and when: ________________

____

Current and Past Medical History (Check all those apply.)

( ) Anemia
( ) Asthma/COPD
( ) Bleeding Disorder
( ) Blood Clot
( ) Cancer
( ) Diabetes
( ) Other: ____
( ) Gout/Arthritis
( ) Heart Disease/Attack
( ) High Blood Pressure
( ) HIV/AIDS
( ) Kidney Disease
( ) Liver Disease/Hepatitis
( ) Lupus/Rheumatoid
( ) MRSA
( ) Neurological Disease
( ) Stomach Ulcer/GERD
( ) Thyroid Disease
( ) None

Name:____

Preferred Pharmacy: ____

Address: ____
Street City State Zip

Phone Number: ____

Allergies:
Do you have <u>any</u> allergies to medications, x-ray dyes, chemicals, etc.? ☐ NO ☐ YES

Are you ALLERGIC to Latex? ☐ NO ☐ YES

Have you or a family member had a reaction to anesthesia? ☐ NO ☐ YES

Allergy	**Reaction**

CURRENT MEDICATIONS			
Please list ANY Prescribed medications, Over-the-Counter medications, Herbal medications, Vitamins, and Dietary Supplements that you are currently taking:			
Name of Medication / Strength	***Dosage (# of pills)***	***Taken How Often***	***Reason***

Social History					
Substance	**No**	**Yes**	**Frequency/Amount**	**When did you start?**	**When did you stop?**
Cigarettes / Cigars					
Chewing Tobacco					
Alcohol					
Caffeine					
Cocaine					
Marijuana					
Heroin					
Methamphetamines					
Narcotics					
Sedatives					

Name:____

Family History								
Please indicate if a family member has/had any of the following:								
	Father	Mother	Brother(s)	Sister(s)	Grandfather	Grandmother	Son(s)	Daughter(s)
Bleeding Disorder								
Any Cancer								
Diabetes								
Heart Disease								
High Blood Pressure								
Lung Disease								
Kidney Disease								
Mental Illness								
Other:								
If deceased, age of death								
Cause of death								

Signed________________________________ Date ____/____/______