NEW PATIENT HISTORY FORM

Patient Information

Vital Signs: Height: Weight:

Race ☐ African American ☐ Asian ☐ Caucasian ☐ Native American ☐ Pacific Islander ☐ Other ☐ Decline to Answer

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Decline to Answer

Preferred Language ☐ English ☐ Spanish ☐ Chinese ☐ Other

Preferred Pharmacy

Referral Source:

Physician: (ex. Dr. John Doe)

Other: (ex. Google Search, Friend, Other Patient)

Chief Complaint

Dominant hand:

☐ Right hand ☐ Left Hand ☐ Ambidextrous

Description of the symptoms (select only one)

☐ Pain ☐ Numbness/Tingling ☐ Fracture ☐ Stiffness Other:

Shoulder	☐ Right	☐ Left	Pelvis	☐ Right ☐ Left	Neck	☐	
Upper Arm	☐ Right	☐ Left	Hip	☐ Right ☐ Left	Upper Back	☐	
Elbow	☐ Right	☐ Left	Thigh	☐ Right ☐ Left	Mid Back	☐	
Forearm	☐ Right	☐ Left	Knee	☐ Right ☐ Left	Low Back	☐	
Wrist	☐ Right	☐ Left	Lower Leg	☐ Right ☐ Left	Buttocks	☐	
Hand	☐ Right	☐ Left	Ankle	☐ Right ☐ Left	Tail Bone	☐	
Thumb	☐ Right	☐ Left	Foot	☐ Right ☐ Left			
Index	☐ Right	☐ Left	Great Toe	☐ Right ☐ Left			
Middle	☐ Right	☐ Left	2nd Digit	☐ Right ☐ Left			
Third	☐ Right	☐ Left	3rd Digit	☐ Right ☐ Left			
Little	☐ Right	☐ Left	4th Digit	☐ Right ☐ Left			
			5th Digit	☐ Right			

☐ Left

History of Present Illness

1. Is your problem the result of an injury or accident?

☐ No injury ☐ Injury ☐ Injury at Work ☐ Auto Accident ☐ Sport Injury ☐ Prior Surgery

How long have the symptoms been present? (ex: 2 days, 4 months)

Onset Date: (ex. mm/dd/yyyy)

2. Are you represented by an attorney? ☐ Yes ☐ No

3. Have you had a problem like this before? ☐ Yes ☐ No

4. Have you been seen in ER for this problem? ☐ Yes ☐ No

5. Rate the pain (10 being the most pain).

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

6. Do the symptoms wake you from sleep? ☐ Yes ☐ No

7. Please describe the symptoms.

☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Shooting

8. What is the timing of the symptoms?

☐ Constant ☐ Intermittent (comes & goes)

9. Is the problem getting better or worse?

☐ Getting better ☐ Getting worse ☐ Unchanged

10. What makes the symptoms worse?

☐ Squatting ☐ Kneeling ☐ Sitting ☐ Bending ☐ Stairs ☐ Twisting ☐ Moving ☐ Lying in Bed

☐ Running ☐ Walking ☐ Athletics ☐ Standing ☐ Gripping ☐ Lifting ☐ Reaching Overhead

11. Are there any other symptoms associated to this problem:

☐ Redness ☐ Bruising ☐ Swelling ☐ Numbness ☐ Stiffness ☐ Limping ☐ Clicking ☐ Locking

☐ Popping ☐ Tingling ☐ Weakness ☐ Giving way

Staff Enter History (Please type full sentences)

Prior Treatment / Testing

Have you had any prior tests for this problem?

☐ None ☐ X-rays ☐ MRI ☐ CAT Scan ☐ Nerve Test (EMG) ☐ Bone Scan

Have you had any prior treatments for this problem? ☐ Yes ☐ No

Type of treatment:	Status of symptoms after treatment (Select only those that apply):	Date treatment was received:
Ice	☐ Improved ☐ Worsened ☐ Unchanged	
Heat	☐ Improved ☐ Worsened ☐ Unchanged	
Rest	☐ Improved ☐ Worsened ☐ Unchanged	
NSAIDs	☐ Improved ☐ Worsened ☐ Unchanged	
Muscle Relaxers	☐ Improved ☐ Worsened ☐ Unchanged	
Chiropractor	☐ Improved ☐ Worsened ☐ Unchanged	
Physical Therapy	☐ Improved ☐ Worsened ☐ Unchanged	
Home Exercise Program	☐ Improved ☐ Worsened ☐ Unchanged	
Surgery	☐ Improved ☐ Worsened ☐ Unchanged	
Injections	☐ Improved ☐ Worsened ☐ Unchanged	
Bracing	☐ Improved ☐ Worsened ☐ Unchanged	
Tens Unit	☐ Improved ☐ Worsened ☐ Unchanged	

Other/Comments:

Past Surgical History

Select all previous hospitalizations/surgeries: ☐ **None**

☐ Aneurysm (Brain) Surgery
☐ Aortic Bypass / Vascular Surgery
☐ Appendectomy
☐ Cataract (Eye) Surgery
☐ Cholecystectomy (Gallbladder)
☐ Heart Surgery
☐ Hernia Repair
☐ Hysterectomy
☐ LAP Band / Gastric Bypass Surgery
☐ Lumpectomy
☐ Mastectomy
☐ Malignancy / Cancer
☐ Stents

Other Surgery:

Orthopedic Surgery: ☐	Right	Left
Arthroscopy: Knee	☐	☐
Arthroscopy: Shoulder	☐	☐
Carpal Tunnel Release	☐	☐
Rotator Cuff Repair	☐	☐
Total Hip Replacement	☐	☐
Total Knee Replacement	☐	☐
Total Shoulder Replacement	☐	☐

Spinal Surgery - Indicate Level:
Other Orthopedic Surgery:

Medical Questions

Mark all that currently apply:

☐ Metal in body ☐ Claustrophobic ☐ Pregnant ☐ Sleep Apnea ☐ Use a C PAP ☐ Snores

Are you taking blood thinners? ☐ Yes ☐ No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months? **Comments**

					NONE
1) Neurological	☐ Change of Sensation	☐ Numbness/Tingling	☐ Seizures	☐	
	☐ Unsteady Gait/Poor Balance				
2) Musculoskeletal	☐ Joint Pain	☐ Joint Stiffness	☐ Muscle Pain	☐	
	☐ Swelling	☐ Instability	☐ Weakness		

FAMILY HISTORY

Have any direct relatives had any of the following disorders? ☐ None for all

Father:	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
	☐ Bleeding Problems	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
	☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer

Comments:

Mother:	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
	☐ Bleeding Problems	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
	☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer

Comments:

Sibling:	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
	☐ Bleeding Problems	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
	☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer

Comments:

SOCIAL HISTORY

1. Do you smoke tobacco? ☐ Current, every day smoker ☐ Current, some days smoker ☐ Former Smoker ☐ Never

☐ Heavy tobacco smoker ☐ Light tobacco smoker

2. Do you drink alcohol? ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

3. Marital History: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership

4. Are you currently working? ☐ Yes ☐ No ☐ Retired ☐ Disabled

Occupation: Employer: ☐ Student

Enter all below information into the Medical Information Tab

Do you have any allergies? Yes ☐ No ☐
Medication, Foods, or Seasonal: ☐ NONE

Latex Allergy? Yes ☐ No ☐

Please list all medications you take on a regular basis: ☐ NONE

Do you have a personal history of any of the following? ☐ NONE

☐ Aneurysm - Where:	☐ Emphysema	☐ Kidney Disease
☐ Angina (chest pain)	☐ Epilepsy	☐ Kidney Stones
☐ Arthritis - Type:	☐ Heart Attack	☐ MRSA Infection
☐ Asthma	☐ Hepatitis - Type:	☐ Pacemaker
☐ Bone or Joint Infections	☐ HIV/AIDS	☐ Phlebitis (Blood Clots)
☐ Cancer - Type:	☐ High Cholesterol	☐ Pulmonary Embolism
☐ Chemotherapy/Radiation	☐ Hypertension	☐ Reaction to Anesthesia - Type:
☐ COPD	☐ Hyperthyroidism	☐ Seizures
☐ Congestive Heart Failure	☐ Hypothyroidism	☐ Stomach Ulcers
☐ Diabetes - Type:	Last A1C	☐ Stroke / TIA
		☐ Tuberculosis

Other:

Created by: Andrea Anneler on 3/24/2020