PATIENT NAME: _____ DOB: _____

HEALTH HISTORY

DATE OF INJURY: _____ Was your injury work related? □ Yes □ No

How were you injured? _____

CHIEF COMPLAINT: What is the reason for your visit? _____

Body Part: _____ □Left □Right □Bilateral

PAIN: Rate your current pain on a scale from 0-10 ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Check all that apply: □ Sharp □ Dull □ Throbbing □ Pins & Needle □ Constant □ Comes & Goes

REVIEW OF SYSTEM: Check the box next to any current symptoms:

□ Fever/Chills	□ Nausea	□ Headaches	□ Blurred Vision	□ Breathing Problems
□ Chest Pain	□ Sore Throat	□ Constipation	□ Urination Problem	□ Rashes

MEDICAL HISTORY: Please check any of your medical conditions:

□ Heart Problems	□ Osteoporosis	□ Diabetes	□ Thyroid Disorder
□ Lung Problems	□ Seizures	□ Stomach Ulcers	□ Rheumatoid Arthritis
□ Kidney Problems	□ Blood Clots	□ Hepatitis C	□ HIV/AIDS
□ High Blood Pressure	□ Other: _____		

Have you ever been diagnosed with an antibiotic resistant infection (i.e. MRSA)? □Yes □No
Are you or could you be pregnant? □Yes □No

HEIGHT: _____ WEIGHT: _____ AGE: _____

SURGICAL HISTORY: Previous surgeries? □Yes □No If yes, please list:
_____
_____

FAMILY HISTORY: Please list any medical conditions that run in your immediate family:
_____
_____

MEDICATIONS: Do you take any medications? □Yes □No If yes, please list:
_____

PAIN CONTRACT: Are you in a pain contract with another physician? □Yes □No If yes, please list:
Physician Name: _____ Clinic Name: _____

ALLERGIES: Do you have any medication allergies? □Yes □No If yes, please list:
_____

SOCIAL HISTORY: Occupation: _____

Do you drink alcohol? □Yes □No
Do you use tobacco products? □Yes □No If yes, what kind:_____

Patient/Legal Guardian Signature: Date: