

# PATIENT HISTORY FORM

Patient \_\_\_\_\_ Date \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_

Insurance \_\_\_\_\_ Referring Physician \_\_\_\_\_ Occupation \_\_\_\_\_

Why are you here today? \_\_\_\_\_ Extremity: Right Left

*Circle as many as needed to explain symptoms associated with your injury/illness*

Location: Front Back Inside Outside Onset: Sudden Chronic Date \_\_\_\_\_

Cause: Auto accident Fall Repetitive use Sports Injury Other \_\_\_\_\_

Severity: Mild Moderate Severe No pain Improving Worsening

Aggravating Factors: Weight Bearing Squatting Lifting Sitting Standing Walking Running Overhead Motion

Relieving Factors: Pain Medicine Anti-Inflammatory Ice Physical Therapy Heat

Prior Tests: X-ray MRI CT EMG/NCS

Prior Treatment: None Medicine Splint Surgery Physical Therapy Chiropractor

## Past Medical History

Asthma Diabetes Stroke Hernia Hypertension Heart Disease Seizures Blood Clot Ulcer Cancer(type) \_\_\_\_\_

Past Surgeries: Appendectomy Tonsillectomy Other \_\_\_\_\_

Family History: Diabetes Heart Disease Cancer (type) \_\_\_\_\_

Social History: Smoke \_\_\_\_\_ packs per day Alcohol: Mild Moderate Heavy Recreational Drugs \_\_\_\_\_

## REVIEW OF SYSTEMS: *Have you had any of the following symptoms recently?*

General: Fever Chills Skin: Rash New skin lesions Eyes: Ear pain Difficulty hearing Ear: Ear pain Difficulty hear

Mouth: Sore throat Neck: Pain Swelling Respiratory: Shortness of breath Cough Wheezing

Cardiac: Chest pain Palpitation Syncope Gastrointestinal: Abdominal Pain Nausea Vomiting Diarrhea Bloo

Genitourinary: Pain urinating Increase frequency Urgency Hesitancy

Musculoskeletal: Back pain

Neurological: Numbness Tingling Endocrine: Cold intolerance Weight loss/gain Increased thirst

Hematological: Easy bruising or bleeding Psychiatric: Anxiety Depression

Was this an accident? \_\_\_\_\_ If so was it work related? \_\_\_\_\_ Date of Injury \_\_\_\_\_

How and where did the accident happen? \_\_\_\_\_

Patient Signature \_\_\_\_\_