

Name: _____
 Age: _____ Who referred you? _____
 Who is your primary care doctor? _____
 If so, approx. when? _____

Describe your injury/problem: _____

What side is affected? R L When did your injury/problem start? _____

Quality of pain (check): Sharp Burning Dull Throbbing Night Pain? YES NO

Severity (How bad does it hurt?): 1 2 3 4 5 6 7 8 9 10

What makes it worse? _____

What makes it better? _____

What treatments have you tried? _____

Please List:

Medications: _____

Allergies: _____

Previous surgeries/hospitalizations: _____

Please check all the medication problems you have:

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Weight Change (+ or -) | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Urinary / Bladder Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Depression | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stomach/Bowel Syndrome | <input type="checkbox"/> Fibromyalgia / Rheumatoid |
| <input type="checkbox"/> Breathing Problems (Asthma) | | |

Family History: Heart Disease Cancer Bleeding Problems Anesthesia Problems

Alcohol Use: YES NO # of drinks /day: _____ Smoker: Yes No # of packs/day: _____

Help at home: YES NO Who: _____

Occupation: _____ Employer/School: _____

Height: _____ Weight: _____ Dominant Hand: R L

X-rays for this injury: YES NO Where: _____

Signature: _____ Date: _____