



Today's Date _____

PATIENT INFORMATION

Name _____

Referring Physician _____

Height _____ Weight _____

What are you being seen for today? (Please include Right or Left body part)

Work related? Yes No Other injury? Yes No

Injury date _____

Date reported to employer _____

Attorney's name _____

SYMPTOMS

Describe your symptoms _____

When (a) and How (b) did your symptoms begin?

a. _____

b. _____

Check all tests performed in the past four months:

X-rays MRI CT scan Blood work

Bone density Bone scan EMG Myelogram

Arteriogram Other _____

MEDICATIONS

List the name, dosage, and frequency of all medications you are currently taking.

Medication	Dosage	Frequency

Internal Use Only:

Physician's review _____ Date _____

Physician's review _____ Date _____

Physician's review _____ Date _____

Physician's review _____ Date _____

MEDICAL HISTORY

Check all health problems YOU have had:

Diabetes Heart disease High blood pressure

Lung disorder Stroke Neurological disorder

Hepatitis Sleep apnea HIV

Asthma Cancer Depression

Other _____

Check all the surgeries YOU have had:

Joint surgery Spine surgery Heart

Hysterectomy C-section Tonsillectomy

Appendectomy Gallbladder

Other _____

FAMILY HISTORY

Check all health problems blood members of your family have had, and list that relative.

Arthritis Osteoporosis

Cancer Diabetes

Heart disease Scoliosis

Bleeding disorder Stroke

Other _____

SOCIAL HISTORY

Do you smoke? Yes No # Packs per day: _____

Do you drink alcohol? Yes No # Drinks per day: _____

Occupation _____

ALLERGIES

List the name of any drugs you are allergic to, and what it does when taken.

LATEX ALLERGY

REVIEW OF SYSTEMS

Check Yes or No to EACH item below:

Y N Fever, chills Y N Night sweats

Y N Mood changes Y N Weight gain/loss

Y N Headaches Y N Vision changes

Y N Shortness of breath Y N Chest pain

Y N Irregular heartbeat Y N Limb swelling

Y N Stomach ulcers Y N Jaundice

Y N Frequent/painful urination Y N Joint pain

Y N Night pain Y N Anemia

Y N Blood transfusion Y N Bleeding disorder

Y N Other _____

