MEDICAL HISTORY FORM

LAST NAME: ____________________________ FIRST NAME: ____________________________MI: ______ TODAY'S DATE: ____/____/_____

DATE OF BIRTH: ____/____/_____ CURRENT AGE: _________ EMAIL ADDRESS: ____

PRIMARY CARE PHYSICIAN: ________________________________ REFERRING PHYSICIAN: _____________________________________

CHIEF COMPLAINT (Reason for today's visit): ____

DID THE PROBLEM RESULT FROM A SPECIFIC INJURY? ☐ NO ☐ YES DATE OF INJURY: ____/____/_____

IS THIS A WORK RELATED INJURY? ☐ NO ☐ YES HAS THE INJURY BEEN REPORTED? ☐ YES ☐ NO

WHAT IS YOUR OCCUPATION? ____

IS THIS INJURY PART OF A LAWSUIT? ☐ NO ☐ YES

PLEASE DESCRIBE THE ONSET OF THE PROBLEM (How did the problem start?): ____

____

DOMINANT HAND: ☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS HEIGHT: ___________ WEIGHT: ___________

SYMPTOMS: What symptoms **RELATED TO TODAY'S VISIT** are you experiencing? (Please check all that apply)

☐ Pain ☐ Weakness ☐ Swelling ☐ Stiffness or Motion Loss ☐ Instability

☐ Locking ☐ Grinding ☐ Clicking ☐ Numbness/Tingling ☐ Catching

☐ Other: ____

Describe the Symptoms: (Quality)

☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Burning ☐ Achy

☐ Shooting ☐ Radiating ☐ Other: ____

How long have you had symptoms? (Duration) ____

How often do you have symptoms? (Timing) ☐ Occasional ☐ Frequent ☐ Constant

When do symptoms occur? ☐ With activity ☐ Morning ☐ Night

Pain Level: (none=0, 10=severe, please circle)

At worst: 1 2 3 4 5 6 7 8 9 10 At best: 1 2 3 4 5 6 7 8 9 10

What makes your symptoms worse? ____________________________ Better? ____

Are you on Narcotic Medication for this issue? ☐ No ☐ Yes, Who is the prescribing Physician? ___________________________________

Have you had any prior injuries to the area? ☐ No ☐ Yes: ____

Have you had any previous treatment for this problem? ☐ No ☐ Yes: ____

If "yes", did any of these treatments provide relief? ☐ No ☐ Yes: ____

CHART#: ___________________________