Patient Demographic & Information Sheet

PLEASE PRINT LEGIBLY AND COMPLETE ALL INFORMATION

Patient Name:____ Age: _________Height:___________ Weight:___________

CHIEF COMPLAINT (Please describe the main reason for your visit today)_____________________________________

What are we seeing you for today? Left / Right (body part) ____

Date of Onset: ____

Was there an injury? YES NO
Was it work related? YES NO Have you filed a claim? YES NO
Was it sports related? YES NO Did you bring a claim form? YES NO
Was there a car accident? YES NO Do you have a lawyer? YES NO
Where did the incident occur? (Geographical location, not body part)____

DID YOU BRING ( ) X-RAYS ( ) MRI ( ) OTHER REPORT ______________________

Please give the details of your chief complaint: ____
____

How long have your symptoms been present?

Was it an acute (new) injury? (circle one) yes no or are you having chronic (old) symptoms? (circle one) yes no

Are symptoms constant intermittent mild moderate severe

Circle all that apply pain stiffness swelling instability weakness numbness/tingling

Aching throbbing dull sharp burning

What makes symptoms **worse**?

What makes symptoms **better**?

What medications have you had for treatment?

What other treatments or tests have you had for this **current** problem? Circle all that apply

X-rays MRI CT scan EMG Surgery Splinting/Bracing Physical Therapy Chiropractic treatment

Other diagnostic tests:

Have you had any injections for this problem? YES NO If yes, then what type?

Were previous treatments helpful to any degree? If so what?

On scale of 1-10 (10 being most severe) circle # that best describes your pain 1 2 3 4 5 6 7 8 9 10

Do you have any pain in your joints at night? YES NO If so which one?

What activities do you enjoy?

Are your complaints affecting your ability to exercise or generally be active? Yes No

Do you know of any other reason why you should not do physical activity?

Since this problem began is the problem (circle): Improving Worsening Unchanged

When are your problems most severe? Morning Afternoon Evening Nighttime Consistent all day____________________

Your goals for treatment are:____

MEDICAL INFORMATION:

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS OR ILLNESSES? (Please answer with a check/circle to each or check/circle NONE)

( ) Lupus	( ) Obesity	( ) Heart Disease	( ) COPD
( ) Rheumatoid Arthritis	( ) Hepatitis	( ) High Cholesterol	( ) Black Outs
( ) Gout	( ) HIV/AIDS	( ) High Blood Pressure	( ) Alzheimer's Disease
( ) Fibromyalgia	( ) Sleep Apnea	( ) Pacemaker	( ) Stroke
( ) Osteoarthritis	( ) Poor Circulation	( ) Heart Attack	( ) Multiple Sclerosis
( ) Anemia	( ) Crohn's Disease	( ) Irregular heart beat	( ) Neuropathy
( ) Bleeding Disorder	( ) Hernia	( ) Mitral Valve Prolapse	( ) Seizures
( ) Broken bones_________	( ) Liver Disease	( ) Heart Stent	( ) Anxiety
( ) Osteoporosis	( ) Kidney Problems	( ) Heart Failure	( ) Depression
( ) Cataracts	( ) Kidney Stones	( ) Asthma	( ) Schizophrenia
( ) Glaucoma	( ) Kidney Failure	( ) Emphysema	( ) Degenerative Disc
( ) Macular Degeneration	( ) Gall Stones	( ) Bronchitis	( ) Herniated Disc
( )Cancer (List Below)	( ) Diverticulitis	( ) Pneumonia	( ) Scoliosis
( ) Diabetes	( ) Ulcers	( ) Tuberculosis	( ) NONE

Other Medical Conditions/Illnesses not listed above: ____

Please give details if you answered "yes" to any of the above: ______________________________________

PREVIOUS SURGERY (Please list and give dates): ____

____

____

ARE YOU ALLERGIC TO ANY MEDICATIONS? Yes No Are you allergic to latex: Yes No

Please list all known drug allergies and the type of reaction. (Example rash, nausea, etc.) PLEASE BE SPECIFIC

____

____

PLEASE LIST ALL CURRENT MEDICATIONS:____

____

TOBACCO USE: ( ) Cigarettes: ________ packs per day _______ years ( ) Snuff/Chewing tobacco ( ) Non-Smoker

ALCOHOL USE: _____________ drinks per day Marital Status: Single Married Divorced Widowed

Employment Status: Employed Unemployed Retired Disabled Other (Please Explain)_____________________

Employer:__________________________________ Occupation:_____________________________________

PRIMARY CARE PHYSICIAN'S NAME:_____________________________________ Phone: (______)____________

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ______________________________________

Address:____ Phone:(_______)__________________________________

PLEASE LIST ANY MEDICAL CONDITIONS THAT ARE IN YOUR FAMILY______________________________

FATHER ( ) DECEASED ( ) LIVING MOTHER ( ) DECEASED ( ) LIVING

REVIEW OF SYSTEMS WORKSHEET

IN THE PAST MONTH, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Circle all that apply)

night sweats	chest pain	nausea	change in urination	stiffness
fever	irregular heart beat	constipation	painful urination	joint pain
chills	wheezing	diarrhea	unusual stress	joint swelling
weight loss	shortness of breath	bruising	anxiety	leg swelling
weight gain	cough	excessive thirst	numbness/tingling	bleeding
fainting	change in bowel habit	vomiting	muscle weakness	swollen glands

NONE

SIGNATURE of PATIENT: ____ DATE: _________________