Patient History Form

Patient Name:	Marital Status: S ___ M ___ D ___ W ___
DOB: / /	Age: Gender: M ___ F ___ Other ___
Name of person making referral	
Primary Care Physician/ Family Doctor	
Body Part: Shoulder or Other _____ Right Left Both	Acute Injury? Yes ___ No ___
Briefly describe reason for your visit and symptoms:	
On a scale of 1-10 rate your pain: (NONE) 0 1 2 3 4 5 6 7 8 9 10 (SEVERE)	
Approximate date of onset or date of injury: _____	Right Handed or Left Handed
Resulting From: Accident____ Sports____ Worker's Comp Claim ____ Involving Lawsuit ____	
Check All That Apply: Stiffness ___ Weakness ___ Instability ___ Numbness/Tingling ___	
What makes symptoms better?	
What makes symptoms worse?	
What treatment have you had? (Medication, Physical Therapy/ Chiropractor, Injections, Surgery)	
Were they helpful and to what degree?	

Medication Information

Allergies? None ___ Medications ___ Latex ___ If Yes, please list drug and reaction (be specific)

Current Medications: (This includes over the counter meds, supplements and vitamins)

Medication Name	Dose/Strength	Frequency

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Medical History: Check all that Apply		
Heart Disease ___	High Blood Pressure ___	List all surgeries and dates below:
Stroke ___	Cancer, type _____	
On Blood Thinners ___	Thyroid Disease ___	
Kidney Disease ___	Seizures ___	
COPD/ Emphysema ___	Anemia ___	
Liver Disease ___	High Cholesterol ___	
Diabetes ___	Substance Abuse/Alcoholism ___	
GI Disorders/GERD ___	Psychiatric, type _____	
Blood Disorders ___	Osteoarthritis ___	
Rheumatoid Arthritis ___	Fibromyalgia ___	

Please list or describe other illnesses, hospitalizations, fractures or serious injuries below:

Family History : Check all that Apply	
Diabetes ___	Bleeding/Blood clotting Problems ___
Heart Disease ___	Rheumatoid Arthritis ___
Anesthesia Complications ___	Osteoarthritis ___
Cancer, Type _____	Osteoporosis___

Social History : Check all that Apply (Answers given here are STRICTLY CONFIDENTIAL)	
Occupation _____	# of years ____
Do you smoke/use Tobacco? Yes ___ No ___ Quit___	# of years (ago)___
Do you consume alcohol? Yes ___ No ___ Quit___	# of drinks per day ___
History of alcohol abuse? Yes ___ No ___	Received formal treatment? Yes ___ No ___
Recreational Drug use? Yes___ No ___	Type _____
History of Drug abuse? Yes ___ No ___	Received formal treatment? Yes ___ No ___

Please list any other pertinent information for today's visit: