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**New Patient History**

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| Name |  | | | | | | DOB | |  | | Date |  |
| Height |  | Weight | |  | Dominant Hand: | | | | Right | | Left | Ambidextrous |
| What is the primary reason for your visit today? | | | | |  | | | | | | | |
| What is the cause of your pain? | | | | | |  | | | | | | |
| Is this pain due to an injury? □Yes □ No | | | | | If yes, how did the injury occur? | | | | | |  | |
| When did your symptoms begin? | | | | Month |  | | | | | Year |  | |
| Do you feel your pain is getting | | | better | | worse | | | unchanged | | | | |
| Which of the following activities makes your pain worse? (circle all that apply) | | | | | | | | | | | | |

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| walking | standing | sitting | all physical activities | other |  | | |
| Which of the following makes your pain feel better? | | | | | | | |
| walking | standing | sitting | all physical activities | medication | | other |  |

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| **Conservative Treatment** | | **Beneficial** | | | **Name of Facility** | | | | **Date of last visit** |
| Physical Therapy | | □ Yes | □ No | |  | | | |  |
| Injections | | □ Yes | □ No | |  | | | |  |
| Chiropractic | | □ Yes | □ No | |  | | | |  |
| Medications | | □ Yes | □ No | |  | | | |  |
| Other | | □ Yes | □ No | |  | | | |  |
| **Pain Description** | | | | | | | | | |
| If you feel any of the following symptoms please indicate where you feel them by placing the appropriate letters on the diagram. | | | | | | | | **Alleviating/Aggravating Factors** | |
| numbness = **n** | tingling = **t** | aching = **a** | | stabbing = **s** | | burning = **b** | weakness = **w** | What makes your pain feel better? | |
| In addition, place an **X** on the part of the body where your pain is worse now | | | | | | | |  | |
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| What makes your pain feel worse? | |
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| Rate your daily average pain: | |
| 1 2 3 4 5 6 7 8 9 1 0 | |
| Describe your pain: | |
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| Circle the appropriate number below showing how bad your pain is now:  No pain 1 2 3 4 5 6 7 8 9 1 0 Worst possible pain | | | | | | | | | |

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| **Who is your primary care provider?** | |  | | |
| **Medication History** | | | | |
| Which local pharmacy do you use? | |  | | |
| Do you take any blood thinners? □ Yes □ No | | | | |
| Do you use home oxygen? □ Yes □ No | | | | |
| Pain medications tried: |  | | | |
| Muscle relaxers tried: |  | | | |
| Please list the prescribed ***and*** over-the-counter medications you are currently taking: | | | | |
| **□** I am currently not prescribed any medications | | | **□** I currently do not take over-the-counter medications | |
| **Medication** | **Strength/Dose** | | **How often taken** | **Prescribed by** |
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| **Allergen History** | □ **No Known Allergies** |
| List any medication and non-medication allergies. Non-medication allergies include iodine, latex, adhesive, dyes, etc. | |
| **Medication or Allergen Name** | **Allergic Reaction** |
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| **Patient Health History** | | **□ No diseases or medical conditions listed below** | |
| Check any of the following diseases or medical conditions: | | | |
| □ Pacemaker | □ Diabetes Type I | □ Unusual Childhood Disease(s) | □ Sleep Apnea |
| □ Artificial Joints | Type I Controlled □ Yes □ No | □ Suicide Attempts/Ideation | □ Asthma |
| □ Bleeding Disorder | □ Diabetes Type II | □ AIDS/HIV | □ COPD |
| □ Heart Disease | Type II Controlled □ Yes □ No | □ Hepatitis C | □ Emphysema |
| □ Heart Attack | □ High Blood Pressure | □ Immune System Disorder | □ Ulcers/Colitis |
| □ Heart Surgery | □ High Cholesterol | □ Multiple Sclerosis | □ Polio |
| □ Congenital Heart Defect | □ Liver Disease | □ Pulmonary Embolism | □ Tuberculosis |
| □ Artificial Valves | □ Cancer | □ Thyroid Problems | □ Kidney Disease |
| □ Peripheral Vascular Disease | □ Migraine Headaches | □ Tropical Disease(s) | □ Anemia |

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| **Surgical History** | | **□ No previous surgeries** | |
| **Procedure** | | **Date** | **Surgeon/Facility** |
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| **Image History** | | **□ No past images** | |
| **Body Part** | **Image Modality** (x-ray, MRI, etc.) | **Date** | **Imaging Facility** |
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| Have you ever had problems with anesthesia? □ Yes □ No | |
| If yes, explain: |  |
| Have you ever had a history of infections(s), other than lung/respiratory? □ Yes □ No | |
| If yes, explain: |  |

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| **Family Health History** | **□ Unknown** | **□** **Adopted** | | |
| **Relationship** | **Health Condition** | | **Alive** | **Deceased** |
| Father |  | |  |  |
| Mother |  | |  |  |
| Runs in Family |  | |  |  |

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| **Smoking Status** | | **Fall Risk** | | |
| Do you **currently** use tobacco? | □ Yes □ No | Have you fallen once in the past 12 months? | | □ Yes □ No |
| If yes, how many packs per day? |  | Were you injured in the fall? | | □ Yes □ No |
| How many years have you smoked? |  | Have you fallen more than once in the past | |  |
| Are you a former smoker? | □ Yes □ No | 12 months with or without injury? | | □ Yes □ No |
| What year did you quit? |  |  | |  |
|  |  |  | |  |
| **Alcohol Use** |  | **Recreational Drug Use** | |  |
| Have you ever used alcohol? | □ Yes □ No | Have you ever used recreational drugs? | | □ Yes □ No |
| Do you currently consume alcohol? | □ Yes □ No | Substance(s): |  |  |
| How many drinks per day? |  |  | |  |
| For how many years? |  | How many years have you been using? | |  |
| If quit drinking, what year? |  | Have you had a problem with addiction? | |  |
|  |  | If you used and quit, what year did you quit? | |  |
| **Medical Marijuana Use** |  |  | |  |
| Do you currently use marijuana? | □ Yes □ No |  | |  |
| How much per day? |  |  | |  |
| Number of years? |  |  | |  |
| Does it effectively alleviate your pain? | □ Yes □ No |  | |  |

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| **Review of Systems** | Check those that apply to your current condition | | | **□** **No symptoms listed below** | |
| **GENERAL** | **MUSCULOSKELETAL** | **EYES** | | | **EARS** |
| □ Unexplained fevers | □ Neck pain | □ Visual disturbance | | | □ Hearing loss |
| □ Weight loss | □ Joint pain/swelling | □ Visual change | | | □ Dizziness |
| □ Weight gain | □ Back pain | □ Double vision | | | □Ringing |
| □ Excessive fatigue | □ History of fractures | □ Blurred vision | | |  |
| □ Appetite decrease | □ Muscle pain | □ Dry eyes | | |  |
| □ Sleep disturbance | □ Muscle weakness |  | | |  |
|  | □ Muscle cramps |  | | |  |
|  |  |  | | |  |
| **NOSE** | **MOUTH** | **THROAT** | | | **RESPIRATORY** |
| □ Nose bleeds | □ Dry mouth | □ Dry throat | | | □ Wheezing |
| □ Nasal Obstruction | □ Dentures/partial | □ Sore throat | | | □ Persistent or unusual cough |
| □ Nasal discharge | □ Loose or broken teeth | □ Voice changes | | | □ Shortness of breath |
|  | □ Speech difficulty | □ Hoarseness | | | □ Sleep apnea |
|  |  | □ Difficulty swallowing | | | □ Night sweats |
|  |  |  | | | □ Breathing difficulty |
|  |  |  | | |  |
| **CARDIOVASCULAR** | **GASTROINTESTINAL** | **GENITOURINARY** | | | **ENDOCRINE** |
| □ Rapid/Irregular heart beat | □ Abdominal pain | □ Urinary Incontinence | | | □ Intolerance to □ heat □cold |
| □ Chest pain | □ Nausea | □ Urinary Retention | | | □ Abnormal skin color change |
| □ Chest pressure | □ Vomiting | □ Urinary Frequency | | | □ Excessive thirst |
|  | □ Bowel habit changes | □ Painful Urination | | | □ Dryness of the □ hair □skin |
|  | □ Blood in stools |  | | |  |
|  | □ Bowel incontinence |  | | |  |
|  | □ Constipation |  | | |  |
|  | □ Diarrhea |  | | |  |
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| **PSYCHIATRIC** | **BLOOD & LYMPH SYSTEM** | **NEUROLOGICAL** | | | **NEUROLOGICAL** cont. |
| □ Depression | □ Swollen lymph nodes | □ Walking difficulty | | | □ Seizure disorder |
| □ Hallucinations | □ Abnormal bleeding | □ Pain going down arms | | | □ Involuntary limb movement |
|  | □ Bleeding disorder | □ Pain going down legs | | | □ Disturbance of smell |
|  | □ Bruise easily | □ Paralysis | | | □ Facial numbness/weakness |
|  | □ Lower extremity swelling | □ Headaches | | | □ Disturbance of taste |
| **WOMEN ONLY** |  | □ Prior head injury/skull fracture | | | □ Loss of consciousness |
| □ Currently pregnant |  | □ Weakness | Location | |  |
| □ Currently in menopause |  | □ Numbness | Location | |  |
|  |  | □ Tingling | Location | |  |

**Please sign and date this form as being true and correct:**

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| --- | --- |
|  | |
| Patient Signature | Date |
|  | |
| Reviewed and verified by office staff | Date |