NAME: _____ DOB: _____

You are here for what body part (what side)? _____ How long has it hurt?_____
Date of Injury: _____ Are you Right-Handed or Left-Handed? _____
If injury, briefly explain what happened: _____

What treatments have you **tried** in the past? (*CIRCLE* **ALL** THAT APPLY) Tylenol Ibuprofen Aleve Supartz Ice Heat Elevation Physical Therapy Surgery Brace Biofreeze Steroid Injection Percocet (Oxycodone) Vicodin (Hydrocodone) Mobic (Meloxicam) Ultram (Tramadol)

Pharmacy: _____ City and Street:_____

Who Referred you here? _____ Is this WORKER'S COMPENSATION? Yes or No
Primary Care Doctor: _____ City/Practice Name: _____
Specialist Doctor Names:_____ Dentist: _____

***Circle* any health problems *YOU* have or are being treated for.**

High Blood Pressure Diabetes History of Heart Attack History of Stroke Heart Disease
Thyroid Condition High Cholesterol History of Blood Clot Arthritis Gout Rheumatoid Arthritis Lupus
History of Cancer: What type and when?_____

Please list your current medications with dosages and how often you take them.
If you have a list or actual medicines, give it to nurse later.

_____ _____
_____ _____
_____ _____
_____ _____

Are you **allergic** to any medicines? Yes or No If so please list:_____
Do you have a metal allergy? _____

***Circle* any problems your immediate *family* has a history of.**

High Blood Pressure Diabetes History of Heart Attack History of Stroke Heart Disease
Thyroid Condition High Cholesterol History of Blood Clot Arthritis Gout Rheumatoid Arthritis Lupus
History of Cancer

Do you smoke? Yes or No How much per day? _____ Did you used to smoke? Yes or No
Do you drink alcohol? Yes or No Please *circle* how much/often: Rarely Occasionally Socially Moderately
Are you retired? Yes or No Do you work? Yes or No Where: _____
Who lives with you? _____ *Circle*: Married Divorced Widowed Single

Please list all your past surgeries and years performed.

_____ _____
_____ _____
_____ _____

***CIRCLE* ONLY WHAT YOU HAVE HAD IN THE PAST 12 HOURS**

Appetite Loss, Chills, Fatigue, Fever, Weakness, Weight Gain and Weight Loss.
Bruising, Itching, Rash, Wound.
Blurred Vision, Diplopia (double vision), Eye Pain, Eye Discharge, Light sensitivity, Eye Redness,
Hearing Loss, Ear Pain, Nose Bleed, Nasal Congestion, Throat Pain and Difficulty Swallowing.
Neck Swelling. Cough, Difficulty Breathing and Hemoptysis (coughing up blood)
Chest Pain, Edema, Elevated Blood Pressure, Orthopnea (shortness of breath when lying down), Palpitations, Shortness of Breath.
Abdominal Pain, Constipation, Diarrhea, Bloody Stool, Nausea and Vomiting.
Blood in Urine, Painful urination, Frequency and Blood in urine.
Dizziness, Fainting, Headaches, Numbness, Seizures.
Anxiety, Depression, Hallucinations. Thank you for filling this out so we may better serve you.