



PATIENT HISTORY

First _____ Last _____ DOB _____ Age _____
Height _____ Weight _____ Male Female Hand Dominance: Right Left
Who referred you to the clinic? _____
Pharmacy name and address: _____

List all current medications and dose (include non prescription and herbal supplements). None List Attached

Medical History: (Please include any medical conditions you have been treated for.)

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> History of Steroid Use | <input type="checkbox"/> GI Disease | <input type="checkbox"/> Gout |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Diabetes | <input type="checkbox"/> History of Blood Clots | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS/Hepatitis |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Rheumatoid Arthritis | Other _____ | <input type="checkbox"/> Neurologic Disease | <input type="checkbox"/> MRSA |

Use of Alcohol

- Never
- Rarely
- Moderate
- Daily

Use of Tobacco

- Never
 - Previously, but quit
 - Currently
- _____ packs per day

Family History: Do any immediate family members have or have had:

- | | | | |
|--|--|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Blood Clots or Pulmonary Embolism | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Diabetes | |

Do you have any drug allergies? Yes No

List drug allergies _____

Past Surgeries/Dates: _____

Date of Injury: _____ **Result of:** Sports On the Job Auto accident

How did injury occur? _____

Injury Location: Right Left

- | | | | | | |
|---------------------------------|-------------------------------|--------------------------------|--------------------------------|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Finger | <input type="checkbox"/> Hand | <input type="checkbox"/> Wrist | <input type="checkbox"/> Elbow | <input type="checkbox"/> Arm | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Leg | <input type="checkbox"/> Knee | <input type="checkbox"/> Foot | <input type="checkbox"/> Ankle | <input type="checkbox"/> Toe |

What symptoms are you experiencing?

- | | | | | |
|-----------------------------------|------------------------------------|--------------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Locking | <input type="checkbox"/> Grinding | <input type="checkbox"/> Catching | <input type="checkbox"/> Weakness | <input type="checkbox"/> Popping |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Other _____ | | |

Have you had any studies or testing for this injury?

- | | | | | |
|--------------------------------|------------------------------|-----------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> X-ray | <input type="checkbox"/> MRI | <input type="checkbox"/> CT | <input type="checkbox"/> EMG/NCV | <input type="checkbox"/> Other _____ |
|--------------------------------|------------------------------|-----------------------------|----------------------------------|--------------------------------------|

Place and date of these studies: _____