New Patient History Form

Date ________________

Patient Name __________________ Email ____________________ DOB __________

Height ___ ft ____in Weight_____lbs □ Male □ Female □ Right-Handed □ Left-Handed

Occupation ___________________________ Primary Care Physician __________________

Referred by/How did you find this doctor ________________________

Reason for today's visit/Chief Complaint: ____

□ **Right** □ **Left** □ **Both** How long has this been a problem? __________________________

Did you have an injury? □ Yes □ No If Yes, Date of injury/Describe injury

____

Work-related? □Yes □ No

Are you experiencing any of the following (Please Check)

□ Pain □ Swelling □ Redness □ Limited Motion □ Muscle Weakness
□ Loss of Muscle □ Popping □ Locking/Catching □ Stiffness □Numbness/Tingling
□ Mass □ Deformity

Have you been treated for this problem before? □ Yes □ No

What kind of treatment? □ Medication □ Injection □ Splint/Brace □ Therapy □ Surgery

□ Xray/MRI/Ultrasound □ Nerve Test □ Other __________________________________

Have you ever taken steroid medications (Cortisone, Prednisone, etc)? □ No □ Yes
(List) ____

Do you have any allergies to medications? □ No □ Yes (List) _________________________

Please list ALL Medications/Supplements/Herbs Taking: *(attach a separate page if needed)*

MEDICATION NAME	DOSE/FREQUENCY		MEDICATION NAME	DOSE/FREQUENCY

Tobacco Use □ Never Smoker □ Former Smoker □ Current Smoker;Type & Amount/Day ____

Chew Tobacco □ **No** □ **Yes**

Caffeine Use □ **No** □ **Yes** **Frequency/Type**

Alcohol Use □ **No** □ **Yes** **Frequency/Type**

Exercise □ No □ Yes (Type/Frequency/Hours per week)

Do you play sports? □ No □ Yes: What Sport________________ Position___________

What level of sport? □ **Junior High or younger** □ **High School** □ **College** □ **Recreational**

□ **Semi-Pro/Professional** □ **Other** ____

Where do you go to School? ____________________ Grade? ___________________

Do you have any hobbies? □ No □ Yes; Please list. ______________________________

Have you Ever Had Surgery? □ No □ Yes; Please list ALL Surgeries (Include Dates):

____

Health History: Please Mark/Indicate any Illness/Condition YOU or your Immediate Family Members have had:

	YOU	Relative			YOU	Relative
Diabetes				Psychiatric Disease		
Liver Trouble				High Blood Pressure		
Blood Clot/Stroke				Unusual Reaction to Anesthesia		
Cancer (Type)				Sudden Death		
Arthritis (Type)				Other (Identify)		

Do You Have Diabetes? □ No □ Yes If Yes Most Recent A1C:

Have you had gastric bypass surgery/sleeve? □ No □ Yes

Females Only:

Are You Pregnant? □ No □ Yes Do you take Birth Control? □ No □ Yes How Long?

Are you on Hormone Therapy? □ No □ Yes