

For us to properly process your chart, please complete fully and print clearly. Thank you!

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
First Middle Last  
 DOB: \_\_\_\_\_ Age: \_\_\_\_ Sex: M F  
 Address: \_\_\_\_\_  
 Social Security#: \_\_\_\_\_ Marital Status (please circle): S M D W Sep  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Patient Home#: \_\_\_\_\_ Patient Cell#: \_\_\_\_\_ Patient Work#: \_\_\_\_\_  
 Name of spouse or parent, if minor: \_\_\_\_\_ Their work#: \_\_\_\_\_  
 E-mail address: \_\_\_\_\_

How you were referred: ( ) Self ( ) Relative ( ) Friend ( ) Your HMO doctor ( ) Your family doctor ( ) Another doctor  
 Name of referring physician, if applicable: \_\_\_\_\_ Phone#: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Name of your primary care physician: \_\_\_\_\_ Phone#: \_\_\_\_\_  
 Preferred Pharmacy: \_\_\_\_\_ Phone#(if known): \_\_\_\_\_  
 Emergency contact person in case of emergency \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_

What body part(s) is bothering you?: \_\_\_\_\_  
 Which side of your body is bothering you?: (circle one) right left both  
 When did this problem occur? Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM or \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Yrs Ago  
 If this is from an accident, place where this occurred? ( ) Home ( ) Work ( ) Auto Accident ( ) School ( ) Other  
 Previous problems with this area? \_\_\_\_\_  
 Briefly describe what happened or what is bothering you: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**WHAT HAVE YOU DONE FOR IT?**

What makes it better? \_\_\_\_\_  
 What makes it worse? \_\_\_\_\_  
 List muscle relaxants, anti-inflammatories or pain medications you have taken for this problem: ( ) Have not taken any

Check box if you have tried: ( ) Injections ( ) Physical Therapy ( ) Splinting ( ) Tens Unit

Year	Surgery Type	Year	Surgery Type
_____	_____	_____	_____
_____	_____	_____	_____

What?	When?	Where?	What?	When?	Where?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Has any member of your family been treated by our group before? ( ) Yes ( ) No



**FAMILY MEDICAL HISTORY**(please check off, where appropriate, any of the below conditions for any member in your family to include father, mother sister, brother and grandparents)

No known family history for the below conditions

- |                                     |  |  |   |
|-------------------------------------|--|--|---|
| <input type="checkbox"/> AIDS/HIV   | <input type="checkbox"/> Asthma          | <input type="checkbox"/> Cancer-Prostate | <input type="checkbox"/> Heart disease/Heart Attack |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer-Breast   | <input type="checkbox"/> Depression      | <input type="checkbox"/> High Blood Pressure        |
| <input type="checkbox"/> Alzheimers | <input type="checkbox"/> Cancer-Cervical | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Kidney Disease             |
| <input type="checkbox"/> Anemia     | <input type="checkbox"/> Cancer-Colon    | <input type="checkbox"/> Drug abuse      | <input type="checkbox"/> Osteoporosis               |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Cancer-Lung     | <input type="checkbox"/> Gout            | <input type="checkbox"/> Stroke                     |

Other \_\_\_\_\_

**REVIEW OF SYSTEMS**(please check all which apply)  I do not have any of the below conditions

**CONSTITUTIONAL**

- |                                      |                                       |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Insomnia     |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Fatigue      |
| <input type="checkbox"/> Fever       | <input type="checkbox"/> Chills       |
| <input type="checkbox"/> Weakness    | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Malaise     |                                       |

**RESPIRATORY**

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Wheezing    |
| <input type="checkbox"/> Cough               | <input type="checkbox"/> TB exposure |
| <input type="checkbox"/> Breathing pain      |                                      |

**GASTROINTESTINAL**

- |   |   |
|---|---|
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Nausea           | <input type="checkbox"/> Heartburn      |
| <input type="checkbox"/> Vomiting blood   | <input type="checkbox"/> Jaundice       |
| <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Constipation   |
| <input type="checkbox"/> Dark Stool       |   |

**DERMATOLOGY**

- Contact Allergy  
 Rashes

**METABOLIC**

- |  |  |
|--|--|
| <input type="checkbox"/> Cold Intolerant | <input type="checkbox"/> Heat intolerant |
|--|--|

**IMMUNOLOGICAL**

- |  |  |
|--|--|
| <input type="checkbox"/> Asthma                              | <input type="checkbox"/> Bee sting allergy |
| <input type="checkbox"/> Contact dermatitis. To what?: _____ |  |
| <input type="checkbox"/> Food allergies. To what?: _____     |  |

**HEENT**

- |  |  |
|--|--|
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Vertigo(world spinning) |
| <input type="checkbox"/> Double vision       | <input type="checkbox"/> Difficulty swallowing   |
| <input type="checkbox"/> Blurred vision      | <input type="checkbox"/> Hearing Loss            |
| <input type="checkbox"/> Ringing in the ears |  |

**CARDIOVASCULAR**

- Chest Pain  
 Feel heart beating  
 Fainting spells

**GENITOURINARY**

- Frequency  
 Urgency  
 Blood in urine  
 Frequent night-time urination  
 Incontinence

**NEUROLOGICAL**

- |   |   |
|---|---|
| <input type="checkbox"/> Seizures               | <input type="checkbox"/> Incoordination     |
| <input type="checkbox"/> Tremors                | <input type="checkbox"/> Difficulty walking |
| <input type="checkbox"/> Numbness/Tingling      | <input type="checkbox"/> Memory Loss        |
| <input type="checkbox"/> Dizziness/Light-headed | <input type="checkbox"/> Depression         |

**HEMATOLOGIC**

- |  |  |
|--|--|
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Easy bleeding |
|--|--|

**REPRODUCTIVE**

- Pain interfering with sex

**HEIGHT, WEIGHT AND HAND DOMINANCE**

What is your? Height \_\_\_\_\_ Weight \_\_\_\_\_ Are you? Right Handed \_\_\_ Left Handed \_\_\_ Ambidextrous \_\_\_

**END OF FORM**

Reviewed by(Provider signature): \_\_\_\_\_ Date Reviewed: \_\_\_\_\_

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