Patient information:

Name: _____ Preferred name: _____

Date of Birth: ___ / ___ / _____ Age: ____ Height: _____ Weight: _____ PCP: _____

Dominant hand: ▢ R ▢ L Occupation: _____ ▢ Retired ▢ Student ▢ Disabled

How did you hear about us? _____

Allergies: _____ Do you take a blood thinner? ▢ Yes (_____) ▢ No

Do you have a history of: ▢ Heart attack (Year: _____) ▢ Blood clot (Year: _____) ▢ Diabetes

▢ Stroke (Year: _____) ▢ Cancer (Type: _____) ▢ Gout ▢ Thyroid disease

▢ Stomach ulcer/gastritis ▢ Other pertinent history: _____

Do you use tobacco? ▢ Yes ▢ No Do you drink alcohol? ▢ Yes ▢ No

What is your overall goal of today's visit: _____

Reason for today's visit: _____

Briefly describe the problem in your own words: _____

_____

_____

▢ **INJURY** Date: __ / __ / ____	▢ **NO INJURY**
▢ Accident ▢ Sport	When did it start? _____
▢ Auto accident ▢ Injury at work	▢ Sudden onset ▢ Gradual onset

On a scale of 0-10 how severe is your pain? 0 1 2 3 4 5 6 7 8 9 10

How would you describe the pain? ▢ Sharp ▢ Dull ▢ Stabbing ▢ Throbbing ▢ Aching ▢ Burning

Do you have: ▢ Swelling ▢ Bruising ▢ Numbness ▢ Tingling ▢ Locking/Catching ▢ Giving way/weakness

What makes your symptoms **WORSE**: _____

What makes your symptoms **BETTER**: _____

Since the problem started, it is**:** ▢ Getting better ▢ Getting worse ▢ Unchanged

Prior evaluation & treatment of current problem:

Have you had a **similar** problem/injury before? ▢ Yes (When? _____) ▢ No

Have you been **treated** for this current problem? ▢ Yes (When/Where? _____) ▢ No

Imaging/tests: _____ Results: _____

▢ Surgery: _____ ▢ Medication: _____

▢ Injection: _____ ▢ PT/OT: _____

Other: _____

Patient signature: _____ MD/PA signature: _____

Date: __ / __ / ____ Date: __ / __ / ____