

PATIENT NAME: _____

SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	DATE

Height _____ Weight _____ email address: _____

WHO REFERRED YOU TO OUR OFFICE? _____
Address: _____

HISTORY OF YOUR PROBLEM

Which arm is involved? Right Left Dominant Hand? Right Left
Occupation? _____
Where do you work? _____
How did you injure yourself? _____
What do you feel is the cause of the problem? _____
Are you involved in any litigation related to this problem? Yes No Maybe
Is this due to an injury? Yes No Date of injury: _____
Are you disabled? Yes No If yes, please provide date the disability began: _____

Is this a work-related injury? Yes No

If you answered yes to the above question, please fill out the back page.

Is this related to a motor vehicle accident? Yes No **Date of injury:** _____

Have you had Nerve Studies performed? Yes No
If so, when? _____ Where? _____
Have you had x-rays of the injured extremity taken? Yes No
If so, when? _____ Where? _____
Have you had an MRI performed? Yes No
If so, when? _____ Where? _____

WHAT ARE YOUR PRESENT COMPLAINTS?

- What treatment(s) have you tried so far?
- | | | |
|---|---|--|
| <input type="checkbox"/> Rest/Activity Modification | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Pain Medication |
| <input type="checkbox"/> Physical Therapy/Exercises | <input type="checkbox"/> Massage | <input type="checkbox"/> Anti-inflammatories |
| <input type="checkbox"/> Immobilization (Cast, splint, sling) | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Steroid/Cortisone Injection |
| <input type="checkbox"/> Braces/Orthotics | <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Tylenol |

HOSPITALIZATIONS AND SURGERY

SURGERY		DATE	
MEDICATIONS	DOSE	MEDICATIONS	DOSE

ALLERGIES:

Are you allergic to Latex? Yes No

REVIEW OF SYSTEMS (please circle)

Childhood History - None

Scarlet Fever	Rubella	Rheumatic Fever
Polio	Mumps	Diphtheria
Measles	Tetanus	

Constitutional - None

Fever	Chills	Weight Loss
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Ear, Nose, Throat - None

Dizziness	Ear problems	Sinus problems
Cold sore	Deafness	Motion sickness

Cardiovascular - None

Palpitations	Heart Murmur	Chest Pains
High blood pressure	High Cholesterol	
Vascular Disease	Pacemaker	

Respiratory - None

Asthma	Bronchitis	Emphysema
Pneumonia	Shortness of breath	

Gastrointestinal - None

Ulcer	Gall Bladder problems	
Hepatitis	Diarrhea	Black Stool
Blood in Stool		

Genitourinary - None

Prostate Disease	Frequent urination	
Painful urination	Blood in urine	

Musculoskeletal - None

Arthritis	Joint pains	Gout
Rheumatoid arthritis		

Endocrine - None

Diabetes	Thyroid Disease	
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Neurologic - None

Headaches	Migraines	Seizures
Stroke		

Psychiatric - None

Depression	Nervousness	Anxiety
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Hematologic/Lymphatic - None

Bleeding problems	Anemia	Easy Bruising
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Skin - None

Rashes	Itching	
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PAST FAMILY HISTORY

	Self	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY:

Do you smoke? Yes No

of Packs per day? _____

Do you drink alcohol socially? Yes No

of Drinks per week? _____

Do you have a history of alcohol dependency? Yes No

History of Drug Abuse? Yes No

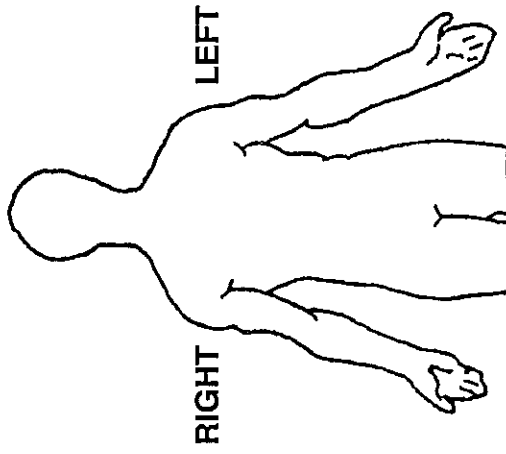
HIV Tested? Yes No

Hobbies: _____

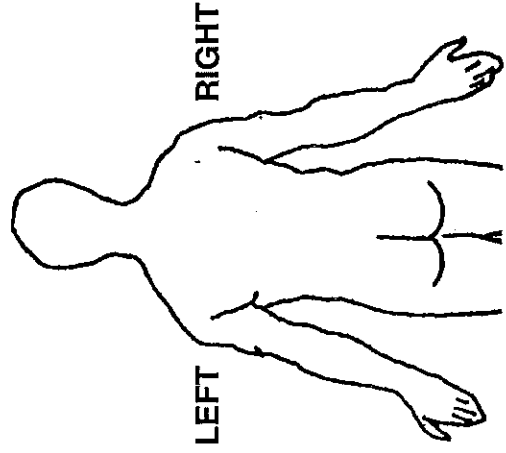
INDICATE THE LOCATION AND TYPE OF PAIN YOU ARE HAVING. DRAW YOUR PAIN WITH THE SYMBOLS LISTED.

ACHING	NUMBNESS	PINS AND NEEDLES	BURNING	STABBING	SCAR
AAAA	000000	XXXX	//////	^^^

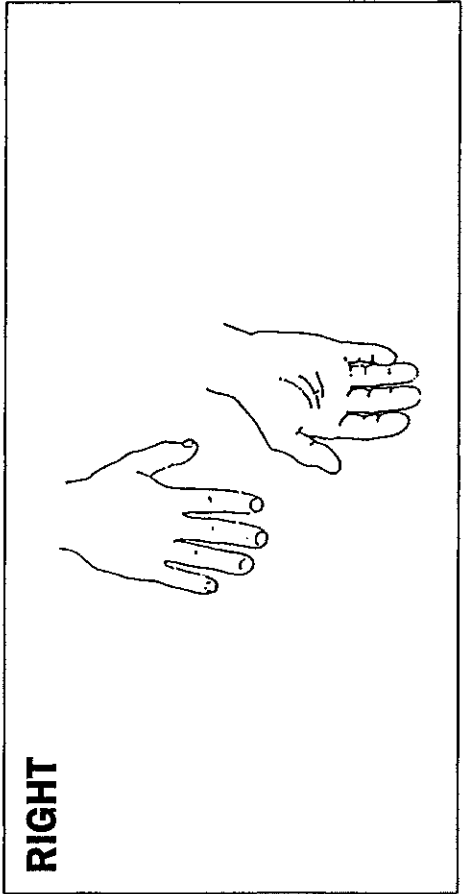
FRONT



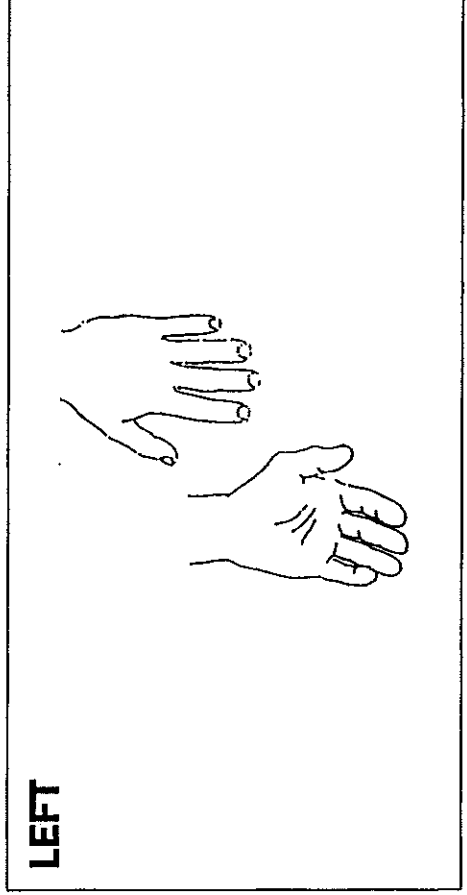
BACK



RIGHT



LEFT



Complete this section only if you are here for a work-related problem

Your answers to these questions are very important. Please take the time to be as accurate and as specific as possible.

WORK HISTORY

What is your current occupation? _____

What company do you currently work for? _____

What was your occupation when you developed the problem that you are being seen for? _____

What company were you working for when you developed this problem? _____

When did you first start working for this company? _____

If you are no longer working for this company, when did you last work for this company? _____

How many hours a day do you (or did you) work? _____

How many hours a week do you (or did you) work? _____

Describe your job in detail: (i.e., The job you were performing when you developed your problem; what you do with your hands and arms at work; how often you perform these activities; how much you lift and how often; whether or not you do data entry - how many hours per day and note if it is continuous or intermittent; if you do repetitive work, how many times per hour this is performed.)

Do you have a second job? Yes No

If yes, please describe what you do and the number of hours per day and week that you work there:

Past Work History

Please list the type of work you did before you worked for the company you were working for when you developed this problem: (i.e., Where you worked; how long you worked there – when to when; and what you did there.)

Are you currently working your regular job? Yes No

Are you on light duty? Yes No

If you are on light duty, what are your work restrictions? _____

Signature: _____ Date: _____