NEW PATIENT HISTORY FORM

Name: _____ DOB: _____

Age: _____ Height: _____ Weight: _____ Occupation: _____ Are you legally disabled? O Yes O No

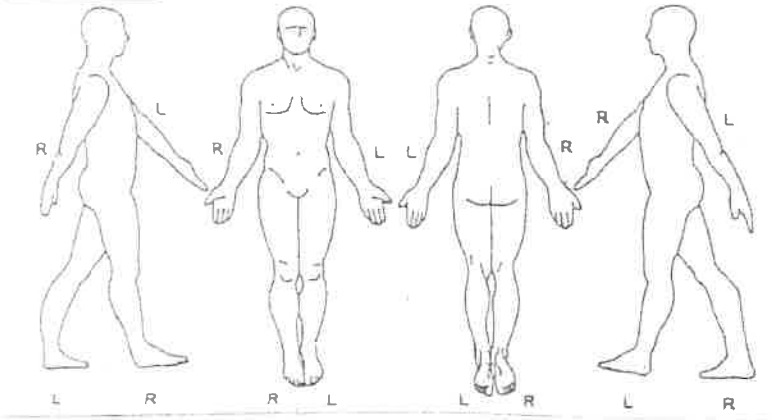
Primary Care MD: _____ Referred to us by: _____

What is the reason for your visit? O Pain O Numbness O Other, please explain: _____

When did this problem begin? _____ How did it start: O Injury O Auto Accident O Sports O No Specific Cause

Please explain: _____

What area of your body is affected? O Right O Left Please circle the affected area(s) on the diagram. Use an **X** to show where it hurts the most.



What kind of pain do you feel? O Dull Ache O Burning O Throbbing O Sharp O Nagging

Associated problems? O Numbness O Tingling O Swelling O Stiffness O Bowel/Bladder Control Problems

How often to the symptoms occur? O On and Off O Constant O When Sleeping O Other

What makes the pain better? _____ What makes the pain worse? _____

Pain Level (0=No Pain, 10=Worst Pain) Right Now: _____ Lowest in the Last Month: _____ Highest in the Last Month: _____

What treatments/therapies have you tried?	Was it helpful?		
O Rest	O Yes	O No	
O Pain Clinic	O Yes	O No	MD name: _____
O Chiropractor	O Yes	O No	
O Injections	O Yes	O No	What kind? _____
O Acupuncture	O Yes	O No	
O TENS Unit	O Yes	O No	
O Physical Therapy	O Yes	O No	How long? _____
O Surgery	O Yes	O No	Please list on page two under Surgical History.
O Medications	O Yes	O No	Please list on page two under Medication List.

Please indicate what diagnostic tests you've have:

Test	X-Ray	MRI	CT Scan	EMG/NCS	Other
Body Area					
Date					
Facility					

New Patient History - Page Two

Medication Allergies? ○ None ○ Penicillin ○ Sulfa ○ Aspirin ○ Codeine ○ Other, please list:

_____

Other Allergies? ○ Yes ○ No Please list: _____

MEDICATION LIST (please list CURRENT medications only)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

SURGICAL HISTORY (please list date, body area and surgery type)

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

MEDICAL CONDITIONS Do you currently experience any of the following? Please check all that apply.

GENERAL
- ○ Weight Loss
- ○ Fevers
- ○ Fatigue

EYES
- ○ Need/Wear Glasses
- ○ Wear Contacts
- ○ Glaucoma

SKIN
- ○ Rash
- ○ Blisters

CARDIOVASCULAR
- ○ Heart Murmur
- ○ Chest Pain
- ○ Irregular Heartbeat

EARS/NOSE/THROAT
- ○ Hearing Loss
- ○ Sinus Infections

IMMUNOLOGIC
- ○ Tuberculosis
- ○ HIV/Hepatitis
- ○ Cancer

GASTROINTESTINAL
- ○ Heartburn
- ○ Stomach Ulcer

RESPIRATORY
- ○ Shortness of Breath
- ○ Sleep Apnea
- ○ Asthma
- ○ COPD/Emphysema

HEMATOLOGIC
- ○ Bleeding Disorder
- ○ Blood Clots

MUSCULOSKELETAL
- ○ Arthritis
- ○ Osteoporosis
- ○ Prior Bone Fracture

URINARY
- ○ Painful Urinating
- ○ Frequent Urinating
- ○ Infection

ENDOCRIN
- ○ Thyroid Issue
- ○ Diabetes

NEUROLOGIC
- ○ Balance Problems
- ○ Dizziness
- ○ Headaches
- ○ Seizures
- ○ Weakness
- ○ Dementia
- ○ Parkinson's

PHYSCHIATRIC
- ○ Depression
- ○ Anxiety
- ○ Panic Attacks

FAMILY HISTORY ○ Heart Disease ○ High Blood Pressure ○ Diabetes ○ Cancer ○ Arthritis ○ Stroke

SOCIAL HISTORY ○ Single ○ Married ○ Divorced ○ Widowed ○ Right-Handed ○ Left-Handed ○ Ambidextrous

Alcohol Use: ○ None ○ Occasional ○ Frequent Smoking: ○ No ○ Yes ____ Packs/Day Recreational Drugs ○ Yes ○ No

What are your interests and hobbies? _____

_____ _____

Patient/Parent/Guardian Signature Date