NEW PATIENT FORM

Patient Name: _____DOB:_____ Date: _____

Chief Complaint/Reason for visit: _____
_____

Ethnicity (please circle one): Caucasian Hispanic Asian Black/African American
Native Hawaiian/Other Pacific Islander American Indian Other

Age:_____ Height:_____ Weight:_____

Hand dominance: ☐ Right ☐ Left ☐ Ambidextrous
Duration of current symptoms: _____Weeks _____Months _____Years
Pain Location:_____

Was pain caused by an injury: ☐ No ☐ Yes
Date of injury_____ Nature of injury_____
_____

Symptoms: ☐ Numbness ☐ Tingling ☐ Weakness ☐ Decrease motion
☐ Catching ☐ Giving way ☐ Locking ☐ Pain

What activities cause pain?_____
_____

Pain is: ☐ Worse ☐ Better ☐ Static (the same)
Pain frequency: ☐ Constant ☐ Occasional
Pain level: ☐ Intolerable ☐ Tolerable
Pain intensity: ☐ Severe ☐ Moderate ☐ Mild

Pain medication you are using:_____
Did medication help? ☐ No ☐ Yes

Steroid (cortisone) injections: ☐ No ☐ Yes How many? _____When?_____ Any relief?_____

Have you had physical therapy? ☐ No ☐ Yes When? _____
How long?_____ Any relief ?_____

Previous surgeries on affected area? ☐ No ☐ Yes

Dates/surgeon's name _____

Previous imaging studies on affected area? ☐ No ☐ Yes Where/when?_____

Does the pain prevent you from doing your activities? ☐ No ☐ Yes
Do you use any splints/braces/walking aides? _____

What activities/motions decrease symptoms? ☐ None ☐ _____
Do you play any sports? ☐ No ☐ Yes

Medical History

Review of Systems: ***Do you have significant problems with these areas:***

Shortness of breath	☐	Sore Throat	☐	Blood in urine	☐	Easily bruised	☐
Fevers, chills, or sweats	☐	Chest pain	☐	Blood in stool	☐	Headache	☐
Ringing in the ears	☐	Palpitations	☐	Constipation	☐	Dizziness	☐
Recurrent bloody nose	☐	Weight loss	☐	Diarrhea	☐	Neurologic	☐
Double or blurred vision	☐	Cough	☐	Rashes	☐	Psychiatric	☐
Depression	☐	Insomnia	☐	Incontinence	☐	Memory loss	☐

Past medical history includes:

Hypertension	☐	Osteoporosis	☐	Asthma	☐	Blood Clots	☐
Heart disease	☐	Ulcer	☐	Cancer	☐	Hepatitis	☐
Hypothyroid	☐	Pulmonary emboli	☐	High Cholesterol	☐	Arthritis	☐
Pacemaker	☐	Diabetes	☐	Anxiety	☐	HIV/AIDS	☐

Other medical conditions:

Surgeries (other than above):

Present Medications:

Allergies: ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Codeine ☐ Latex ☐ None

Reaction/Other allergies: _____

Family/Social History

Family History:

Father: ☐ Alive ☐ Deceased Mother: ☐ Alive ☐ Deceased Siblings: ☐ Alive ☐ Deceased

Rheumatoid arthritis	☐	Diabetes	☐	High cholesterol	☐	DVT	☐
Anesthesia Issues	☐	Heart Disease	☐	High blood pressure	☐	Cancer	☐

Social History:

Do you use tobacco? ☐ No ☐ Former ☐ Yes # of packs per day: _____

Do you drink alcohol? ☐ No ☐ Yes # of drinks per day: _____

Are you currently working: ☐ No ☐ Yes Occupation: _____

I acknowledge that the information provided above related to my family and medical history is accurate and complete. If there are any changes to this information in the future, I will provide any such change at my next scheduled visit.

_____	_____	_____
Patient or Guardian signature	**Date**	**Physician signature**