New Patient Information Form

Date: ____________________

Name: ____ Age: ____________

Name you prefer to be called: ____________________ Dominant Hand: Right Left

Referring Physician: ____

What is your occupation?

____

What problem brings you to see us today?

____

HISTORY OF PRESENT ILLNESS:

Was the onset of the problem (please circle): Immediate / Gradual / Injury / Car Accident

Did the problem occur (please circle): At Home / At Work / other: ____________

How did you injury/problem occur? ____

____

Which side is bothering you (please circle)? Right Left Both

Date of onset? ____________________

Please circle the following that best described your pain and/or symptoms (please circle all that apply):
sharp / stabbing / dull / aching / numb / tingling / burning / constant / intermittent / popping / locking / swelling / pins and needles sensation / other: ______________________________

What makes your pain worse? (please circle all that apply)
Lifting / pivoting / stair climbing / weight bearing / walking / standing / car rides / sports / night time / twisting / squatting / other: ______________________________

What helps relieve your pain? (please circle all that apply)
Rest / ice / elevation / heat / pain medication / nothing / other: ______________________________

PAST MEDICAL HISTORY

Please list any ALLERGIES to medications:

____

Please list any medications that you take on a regular basis (Name, dosage, and PURPOSE):

____

____

____

Please list all the surgeries you have had with the year that you had them:

____

____

____

Medical Illnesses: Have you ever had or now have any of the following?

Diabetes Type I	Yes / No	Lung Disease	Yes / No
Diabetes Type II	Yes / No	Aids or HIV	Yes / No
Heart Attack	Yes / No	Tuberculosis	Yes / No
Heart Failure	Yes / No	Cancer, type__________	Yes / No
Stroke	Yes / No	Bleeding problems	Yes / No
Hepatitis type _____	Yes / No	Blood clots	Yes / No
Jaundice	Yes / No	Mental illness	Yes / No
High Blood Pressure	Yes / No	Lupus	Yes / No
Kidney problems	Yes / No	Asthma	Yes / No
Rheumatoid Arthritis	Yes / No	Ulcer history	Yes / No
Fibromyalgia	Yes / No	Sleep Apnea	Yes / No
Are you pregnant?	**Yes / No**	Hypothyroidism	Yes / No
Last menstrual date:	__/__/__		

Other Medical Conditions: ______________________________

Do you currently or have you ever smoked cigarettes, cigars, or pipe? Yes / No

If Yes, how many per day and for how many years?______________________________

Do you drink alcohol? Yes / No If Yes, how much and how often?______________________________

Have you ever taken drugs other than prescription medication? Yes / No

If yes, please name them: ______________________________

Has anyone in your family ever had (please check all that apply):

High Blood Pressure	_____	Diabetes I or II	_____	Heart Disease	_____
Bleeding Problems	_____	Cancer	_____	Lung Disease	_____
Anesthesia Problems	_____	Tuberculosis	_____		