Patient Name: _____ **Ht:** _____ **Wt:** _____

When was your **most recent** primary care/general physician appointment? _____

Have you had any falls with injury in the past year? (circle) Yes / No If so, how many? _____

REASON FOR VISIT: _____ Date of Injury/Symptom Onset: _____

Describe Injury/Symptoms: _____

Where did it happen? _____ How would you **rate your pain** on a scale of 1-10? _____

Other symptoms? _____ Which is your dominant hand? (circle) L / R / Ambi

Have you had any prior testing for today's complaint? (circle below)

X-Ray / MRI / CT / Nerve Testing / Ultrasound Location/Date: _____

MEDICATIONS: (circle) None / Yes List: _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

MEDICAL HISTORY: (circle if applicable) • NO MEDICAL PROBLEMS •

Diabetes • Insulin • Heart Disease • Gout • AFIB • Other Arrhythmia •

High Blood Pressure • High Cholesterol • Heart attack • Congestive Heart Failure • Stroke •

Blood Clots • Kidney Disease • Acid Reflux • Depression • Irritable Bowel • Parkinson's •

Blood Disorder • Thyroid disease • Urologic problems • Neuropathy • COPD • Asthma •

Alzheimer's/Dementia • Liver Disease • Rheumatoid arthritis • Autoimmune Disease (type) _____

Ulcer (type) _____ • Cancer (type) _____ • Other _____

ALLERGIES: (circle) None / Yes List: _____

PREVIOUS SURGERY: (circle) None / Yes List type along with date: _____ _____ _____

_____ _____ _____ _____ _____ _____ _____

VACCINATIONS: Flu vaccine? Y / N Date Given: _____ Pneumonia vaccine? Y / N Date Given: _____

FAMILY HISTORY: Father's Medical Problems: _____

Mother's Medical Problems: _____

SOCIAL HISTORY: Do you drink alcohol*?* (circle) Yes / No *If yes, how many?* _____ per day / week / month

Do you smoke*?* (circle) No / Current / Former *Quit date*: _____ Other substance abuse _____

REVIEW OF SYSTEMS: (Please circle those that apply) • GOOD GENERAL HEALTH •

Fever • Recent Weight Changes • Glasses/Contacts • Hearing Problems • Wheezing • Skin ulcer •

Shortness of Breath • Chest Pain • Blood in Stool • Anemia • Urinary problems

MD Int: _____

Date: _____

SIGNATURE/DATE:_____