

Patient History

Name:

DOB:

Height:

Weight:

Referring doctor:

Family doctor:

What are we treating you for today: Right Left

Foot/toes	Ankle	Knee	Hip	Back	Shoulder	Elbow
Wrist	Hand	Fingers	Fracture: _____		Other: _____	

How long has it been bothering you?

__ Hours __ Days __ Weeks __ Months __ Years

How did you hurt yourself?

What eases your pain?

What makes your pain worse?

Medications tried / currently being taken for this?

Family History (Only for immediate family)

Cancer:

Heart disease:

Diabetes:

Bleeding disorders:

Social History

Alcohol use:	None	Occasional	Moderate	Heavy
Tobacco use:	Never	Previous	Yes: ____ PPD	Cigar / Chew

Have you had any of the following **health problems**?:

Acid reflux	High blood pressure	High cholesterol	Diabetes	Neuropathy
Fatigue	Heart disease/CAD	Depression	Anxiety	Cancer: _____
Fibromyalgia	Heart attack	Sleep apnea	COPD	Restless leg syndrome
Glaucoma	Thyroid disease	Stroke	Asthma	Migraines
Gout	Chronic pain	Kidney disease	Sciatica	Other: _____

Please list the **medications** you take *If you have a list, we will gladly take a copy instead.

Do you have any **drug allergies**?

Please list all **surgery** you have had