Name:_____ Date of Birth:_____ Age: _____

How did you hear about us? _____ Today's Date:_____

Type of sport / exercise / work: _____

Hand Dominance: ☐Right ☐Left ☐Ambidextrous

Reason for today's visit: _____

When did this problem start?: _____

How did this problem start (what happened)?: _____

_____

_____

_____

Since this problem started is it: ☐Better ☐Worse ☐Same

What best describes your pain? ☐ Sharp ☐Dull ☐ Aching ☐ Throbbing ☐ Electric

Are there any other associated symptoms? ☐Numbness ☐Tingling ☐Weakness ☐Swelling

What actions or activities bring your symptoms on?_____

_____

Rate your pain level from 0-10 (0= none / 10= most severe):

Current: ____/10 Best: ____/10 Worst: ____/10

How long does it last? ☐Seconds ☐ Minutes ☐ Hours ☐ Constant

Does your pain radiate/travel anywhere? _____

What makes your pain worse? _____

_____

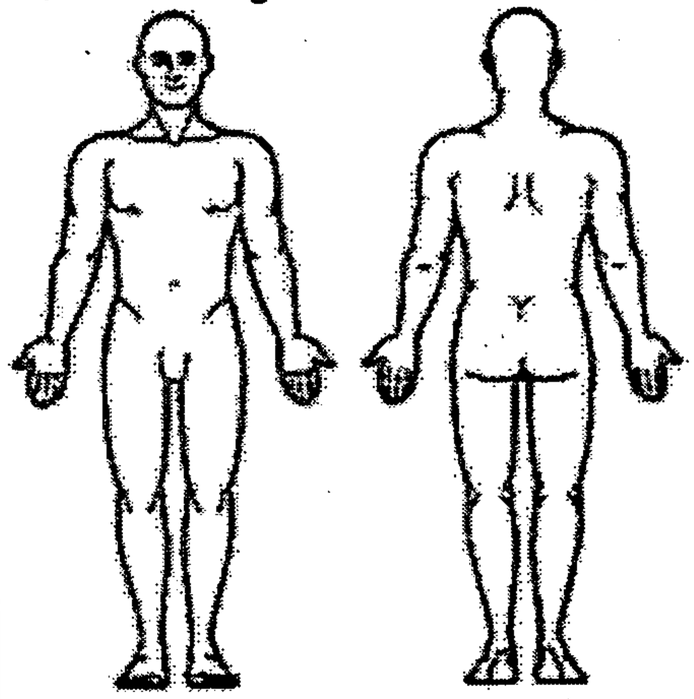
What makes your pain better?_____

_____

Have you had something like this before? _____

_____

Where is your pain located?
(Mark the diagram below with an X)



Have you had any care for this problem prior to today's visit? ☐ Yes ☐ No

Other healthcare providers (doctors, physical therapist, school athletic trainer, etc.): _____

_____

Diagnostic testing (ex. MRI, x-ray, EMG, etc.): _____

Medications (over the counter or prescribed) and/or treatments tried so far: _____

_____

Past Medical History:

- ☐ Migraines/Headaches
- ☐ Eye Problems
- ☐ Hearing deficit
- ☐ Asthma
- ☐ GERD / Reflux / Ulcer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Other Bone/Joint Condition
- ☐ Rheumatologic/Autoimmune Disorder
- ☐ Kidney Disease
- ☐ Cancer
- ☐ Immunodeficiency
- ☐ Skin Condition
- ☐ Circulatory Disorder
- ☐ Other: _____

Please list any medications/supplements that you are taking below:

Please list any allergies you have (include foods, medications, etc.):

Please list any surgeries you've had with the approximate dates:

Please list past hospitalizations with approximate dates and reason:

Medical problems that run in your family:

- ☐ Arthritis
- ☐ Asthma
- ☐ Rheumatological conditions
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Other: _____

Marital Status: ☐ Married ☐ Single

Occupation/Company: _____

Exercise/Activity Level: ☐ None ☐ Mild ☐ Moderate ☐ Vigorous

Average days of moderate to vigorous exercise per week: _____

Average minutes of exercise per session: _____

Smoking Status: ☐ Non-smoker ☐ Smoker

Packer per day: _____ Years: _____

Review of Systems

General:
- ☐ Change in appetite
- ☐ Chills
- ☐ Fever
- ☐ Unexplained weight loss/gain

Allergy:
- ☐ Itching
- ☐ Hives

Eyes:
- ☐ Blurred vision
- ☐ Decreased vision

Ear/Nose/Throat:
- ☐ Decreased Hearing
- ☐ Runny Nose
- ☐ Sore throat

Endocrine:
- ☐ Feel too hot
- ☐ Feel to cold

Respiratory:
- ☐ Cough
- ☐ Shortness of breath

Cardiovascular:
- ☐ Chest pain
- ☐ Difficulty on exertion
- ☐ Irregular heartbeat / palpitations

Gastrointestinal
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Rectal bleeding

Hematology:
- ☐ Easy bruising
- ☐ Prolonged bleeding

Genitourinary:
- ☐ Change in urination
- ☐ Genital discharge/bleeding

Musculoskeletal:
- ☐ Other joint pains
- ☐ Other joint swelling

Vascular:
- ☐ Overly cold extremities

Skin:
- ☐ Rash

Neurologic:
- ☐ Headache
- ☐ Seizures

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Mental / physical abuse
- ☐ Learning Disability

Other: