

**PATIENT INFORMATION SHEET**

**BACKGROUND**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Age: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_  Right-Handed  Left-Handed  
Occupation: \_\_\_\_\_ Hobbies/Sports/Exercise Activities: \_\_\_\_\_  
Referring physician, school, or organization: \_\_\_\_\_  
Pharmacy name and address/phone number: \_\_\_\_\_

**REASON FOR VISIT** (Please provide a brief history of what is bothering you, what body part is injured, and how it happened): \_\_\_\_\_  
\_\_\_\_\_

- How long have you had this problem? \_\_\_\_\_
- Was there an injury?  Yes  No If yes, please provide the date of injury: \_\_\_\_\_
- On a scale of 0-10 (10 being the worst pain you can imagine), how bad is your pain: \_\_\_\_/10
- Have you seen another doctor for this problem?  Yes  No
  - If yes, when and what was the treatment? \_\_\_\_\_
- Have you had Surgery on this body part before?  Yes  No
  - If yes, when and please describe \_\_\_\_\_
- Other Treatments you've tried (circle):  Ice  Heat  Brace  Exercises  Chiropractor
  - Medications (please list: \_\_\_\_\_)
  - Other \_\_\_\_\_

**ALLERGIES** (Please list any known drug allergies)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT MEDICATIONS** (List name & dose of medication):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY**

Do you smoke?  Yes  Never  Former – Year Quit \_\_\_\_\_ If yes, how many packs per day? \_\_\_\_\_  
Do you drink alcohol?  Yes – how much? \_\_\_\_\_  No  
Have you ever had a problem with drug dependence?  Yes  No  
Marital status:  Married  Single  Divorced  Widowed  
Children:  Yes  No How many? \_\_\_\_\_

**SURGICAL HISTORY:** (List any past surgeries, including the month/year of surgery)

\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY:** (Please choose all current and past medical conditions)

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> No medical problems   | <input type="checkbox"/> Emphysema       | <input type="checkbox"/> Kidney failure       | <input type="checkbox"/> Blood clots in legs/lungs |
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> Endometriosis        | <input type="checkbox"/> HIV                       |
| <input type="checkbox"/> Heart attack          | <input type="checkbox"/> Liver disease   | <input type="checkbox"/> Ovarian cysts        | <input type="checkbox"/> Alcoholism                |
| <input type="checkbox"/> Heart failure         | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Kidney stones        | <input type="checkbox"/> Anxiety                   |
| <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Depression                |
| <input type="checkbox"/> Lung disease          | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Osteoarthritis       | <input type="checkbox"/> Schizophrenia             |
| <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> Stomach ulcers  | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Anorexia/bulemia          |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Stroke          | <input type="checkbox"/> Bleeding disorders   |  |
| <input type="checkbox"/> Bronchitis            | <input type="checkbox"/> Seizures        | <input type="checkbox"/> Anemia               |  |

**Are you under a doctor's care for any other medical condition?**    Yes    No

If yes, please explain: \_\_\_\_\_

**FAMILY HISTORY:** (Indicate conditions that run in your close family)

<u>Condition</u>	<u>Relationship</u>	<u>Condition</u>	<u>Relationship</u>
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Cancer: Type: _____	_____
<input type="checkbox"/> Heart disease	_____	<input type="checkbox"/> Gout	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Mental Illness:	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Alcoholism:	_____
<input type="checkbox"/> Bleeding Disorder	_____	<input type="checkbox"/> Kidney Disease:	_____
<input type="checkbox"/> Other:	_____		

**REVIEW OF SYSTEMS:** (Have you experienced any of the following *recently*)

- |   |  |   |
|---|--|---|
| <p><u>General</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Unexplained weight loss</li> <li><input type="checkbox"/> Appetite change</li> <li><input type="checkbox"/> Fevers or chills</li> <li><input type="checkbox"/> Night sweats</li> <li><input type="checkbox"/> Marked fatigue</li> <li><input type="checkbox"/> Difficulty sleeping</li> </ul> <p><u>Ear, Eyes, Nose, Throat</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Difficulty swallowing</li> <li><input type="checkbox"/> Hoarseness</li> <li><input type="checkbox"/> Loss of hearing</li> <li><input type="checkbox"/> Ear pain</li> <li><input type="checkbox"/> Nosebleeds</li> <li><input type="checkbox"/> Gum trouble</li> <li><input type="checkbox"/> Change of vision</li> </ul> <p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Heart or chest pain</li> <li><input type="checkbox"/> Abnormal heartbeat</li> <li><input type="checkbox"/> Poor heart function</li> </ul> | <p><u>Digestive</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nausea or vomiting</li> <li><input type="checkbox"/> Stomach pain or ulcers</li> <li><input type="checkbox"/> Heartburn/acid</li> <li><input type="checkbox"/> Frequent diarrhea</li> <li><input type="checkbox"/> Frequent constipation</li> <li><input type="checkbox"/> Uncontrolled loss of stool</li> <li><input type="checkbox"/> Blood in stool</li> <li><input type="checkbox"/> Hemorrhoids</li> </ul> <p><u>Skin</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Rashes</li> <li><input type="checkbox"/> Frequent itchiness</li> <li><input type="checkbox"/> Easy bruising</li> <li><input type="checkbox"/> Swollen ankles</li> </ul> <p><u>Neurological</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> Blackouts/fainting</li> <li><input type="checkbox"/> Tremors</li> <li><input type="checkbox"/> Headaches/migraines</li> </ul> | <p><u>Psychiatric</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Nervous exhaustion</li> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Paranoia</li> <li><input type="checkbox"/> Obsessive/compulsive behavior</li> </ul> <p><u>Genitourinary</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Burning on urination</li> <li><input type="checkbox"/> Difficulty starting urination</li> <li><input type="checkbox"/> Incontinence</li> <li><input type="checkbox"/> Pelvic pain</li> <li><input type="checkbox"/> Urinate at night more than once</li> </ul> <p><u>Lung</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cough</li> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Productive cough or sputum</li> </ul> |
|---|--|---|