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Patient History

Name: Date:

Age: DOB: Sex: M F (circle one) Height: Weight:

Hand Dominance: RT LT Both

Referring MD: Primary Care Physician:

Drug Allergies:

Pharmacy: Cardiologist: Blood Thinner: YES NO

Current Medications:

History of present illness/injury (reason for your visit)

Reason for Visit: Work Related: YES NO

Date of Onset (WHEN DID IT HAPPEN)

Mechanisim of Injury (HOW DID IT HAPPEN)

DESCRIPTION OF PAIN:

LOCATION:

QUALITY: shooting throbbing sharp burning aching tenderness

SEVERITY (scale 0=minimal / 10=extreme) 0 1 2 3 4 5 6 7 8 9 10

Duration: constant frequent sometimes

SYMPTOMS: swelling bruising numbness tingling grinding popping

What makes it better?

What makes it worse?

TIMING:

- How often does it happen? : During each day/week/ month
- Is it occurring: More often / Less often/ Can't say
- Associated with any other symptom or complaint?
- Mainly at Night/ During the Day/ In the Morning/

Is it associated with any particular activity? YES/ NO

If YES, Explain:

PRIOR TREATMENT FOR THIS PROBLEM(INCLUDE DATES)

Physician/ Hospital:

Medication/ Injections:

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Physical Therapy:

Diagnostic Test: