Name: _____ Date: _____ DOB: _____

Height: _____ Weight: _____

Pharmacy Name:_____ Pharmacy Phone:_____

Primary Care Physician Name: _____ Phone (PCP):_____

HOW YOU HEARD ABOUT US

□ Family/Friend □ Email □ Newspaper / Magazine Ad □ Organization Website □ Internet Search
□ Television Commercial □ Organization Newsletter □ Other _____
□ Referring Physician _____ □ Coach_____ □ Trainer_____

How would you describe your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

CHIEF COMPLAINT

Which joint is bothering you: ☐ Hip ☐ Knee ☐ Shoulder Side: ☐ Right ☐ Left ☐ Both
How long has the pain been going on? Days_____ Weeks _____ Months _____ Years **_____**
Which of the following medications have you tried or are currently taking:
☐ NSAID (Ex: Aleve, Motrin, Mobic, Advil, Celebrex) ☐ Tylenol ☐ Tramadol ☐ Hydrocodone
☐ Other: **_____**

Which of the following have you tried: ☐ Formal Physical Therapy ☐ Home Exercises ☐ Joint injections
If you have received joint injections? If so, which have you tried? ☐ HA (Hyaluronate Acid) injections ☐ Cortisone
☐ Other_____ Last injection date: _____
Results of previous treatment: ☐No Effect ☐Temporary Relief ☐Improved ☐Worsened
Do you use an assistive device? ☐Cane ☐Walker ☐Brace ☐Sling ☐Wheelchair ☐Other: _____
Have you seen another provider for this problem? Who? _____
Have you seen a Pain Management provider: ☐Yes ☐No
Please select all that you have used for pain relief:
☐Physical therapy ☐Chiropractor ☐Psychological therapy ☐Brace support ☐Acupuncture ☐Hot/Cold packs
☐Massage therapy ☐Botox ☐TENS ☐Injections ☐Medications ☐Other_____

SOCIAL HISTORY

Alcohol use: ☐Social Use ☐Daily Use ☐Current Alcoholism ☐History of Alcoholism ☐Never
Tobacco Use: ☐Current Smoker ☐Former Smoker ☐Never Smoked
Packs Per Day? _____ How Many Years? ____ Quit Date? ___
Have you had any recent diagnostic testing/imaging (within 6 months)? ☐Yes ☐No
☐MRI ☐CT ☐X-ray If so, what area of the body? _____

FAMILY HISTORY

Please check all that apply for immediate family members: (M)other, (F)ather, (B)rother,(S)ister,(G)randparent
☐Arthritis **(M/F/B/S/G)** ☐Headaches/Migraines **(M/F/B/S/G)** ☐High Blood Pressure **(M/F/B/S/G)**
☐Cancer **(M/F/B/S/G)** ☐Liver Problems **(M/F/B/S/G)** ☐Diabetes **(M/F/B/S/G)** ☐Kidney Problems **(M/F/B/S/G)**
☐Rheumatoid Arthritis **(M/F/B/S/G)** ☐Stroke **(M/F/B/S/G)** ☐Osteoporosis **(M/F/B/S/G)** ☐Seizures **(M/F/B/S/G)**
☐Heart Problems **(M/F/B/S/G)** ☐Other Medical Problems **(M/F/B/S/G) _____**

Do you have any of the following:

Metal or Jewelry Allergies? Yes ____No_____ What type of Metals? _____
Tape Allergies? Yes ____ No ____ What type of tape/Band-Aids? _____
Latex Allergies? Yes ____ No_____
Medication Allergies? Yes____ No_____ What Medication(s)?_____
_____

Current Medications:	**Dose:**	**Frequency:**	**Current Medication:**	**Dose:**	**Frequency:**

PAST SURGERY HISTORY	**YEAR**
☐ Appendectomy	
☐ Arthroscopy knee (R) (L) (B)	
☐ Arthroscopy hip (R) (L) (B)	
☐ Arthroscopy shoulder (R) (L) (B)	
☐ Back surgery	
☐ Balloon angioplasty	
☐ Bladder Surgery	
☐ Brain Surgery	
☐ Colon Surgery	
☐ Cardiac Valve Replacement	
☐ Carpal Tunnel Syndrome (R) (L) (B)	
☐ Cataract Surgery (R) (L) (B)	
☐ Cesarean Section	
☐ Gall Bladder Surgery	
☐ Gastric Bypass/Sleeve	
☐ Heart Bypass	
☐ Heart Surgery	

PAST SURGERY HISTORY	**YEAR**
☐ Hernia Repair	
☐ Hip Surgery (R) (L) (B)	
☐ Hysterectomy	
☐ Intestinal Surgery	
☐ Kidney stone surgery	
☐ Knee surgery (R) (L) (B)	
☐ Lasik	
☐ Mastectomy	
☐ Neck Surgery	
☐ Pacemaker	
☐ Prostate Surgery	
☐ Shoulder Surgery (R) (L) (B)	
☐ Stent Placement	
☐ Thyroidectomy	
☐ Tonsillectomy	
☐ Vascular Surgery	
☐ Vein Surgery	

CARDIOVASCULAR

- ❍ Aortic Stenosis
- ❍ Atrial Fibrillation/Irregular Heartbeat
- ❍ Carotid Artery Disease
- ❍ Chest Pain
- ❍ Congestive Heart Failure
- ❍ Coronary Artery Disease
- ❍ Elevated Cholesterol/ Triglycerides
- ❍ Heart Attack (MI)
- ❍ Heart Murmur/Heart Valve Issues
- ❍ High blood pressure

METABOLIC

- ❍ Diabetes Mellitus, Type I
- ❍ Diabetes Mellitus, Type II
- ❍ Hypoglycemia (low blood sugar)
- ❍ Thyroid Disease

GASTROINTESTINAL

- ❍ Colitis
- ❍ Crohn's Disease
- ❍ Diverticulosis/Diverticulitis
- ❍ Gall Bladder Problems
- ❍ Heartburn/Reflux
- ❍ Liver Disease
- ❍ Pancreatitis
- ❍ Ulcers

BLOOD

- ❍ Anemia
- ❍ Blood Clots/DVT
- ❍ Hemophilia/Free bleeder
- ❍ Prior Blood Transfusions
- ❍ Pulmonary Embolism
- ❍ Sickle Cell Anemia

MUSCULOSKELETAL

- ❍ Ankylosing Spondylitis
- ❍ Back/Neck Pain
- ❍ Fibromyalgia
- ❍ Gout
- ❍ Osteoporosis
- ❍ Paget's Disease
- ❍ Perthes Disease
- ❍ Inflammatory Arthritis
- ❍ Sciatica
- ❍ Scoliosis
- ❍ Systemic Lupus

NEUROLOGICAL

- ❍ Alzheimer's Disease/ Dementia
- ❍ Carpal Tunnel Syndrome
- ❍ Chronic Headaches
- ❍ Foot Drop/Other Paralysis
- ❍ Migraines
- ❍ Neuropathy
- ❍ Numbness
- ❍ Parkinson's Disease
- ❍ Seizures (Epilepsy)
- ❍ Stroke
- ❍ Tremor

EYES/EARS/NOSE/SKIN

- ❍ Cataracts
- ❍ Eczema
- ❍ Glaucoma
- ❍ Hearing Loss/ Hearing Aids
- ❍ Nose Bleeds
- ❍ Psoriasis
- ❍ Skin Breakdown/Skin Ulcers
- ❍ Skin Infections

RESPIRATORY

- ❍ Asthma
- ❍ Bronchitis
- ❍ COPD/Emphysema
- ❍ Pneumonia
- ❍ Sleep Apnea

PSYCHOLOGICAL

- ❍ Alcohol Abuse/Dependence
- ❍ Anxiety Disorder
- ❍ Bipolar/Manic Depressive Disorder
- ❍ Depression
- ❍ Drug Use/Dependence

INFECTIONS

- ❍ Hepatitis
- ❍ Herpes
- ❍ HIV/AIDS
- ❍ Malaria
- ❍ Rheumatic Fever
- ❍ Tuberculosis
- ❍ Wound Infection/Non-healing Wounds

URINARY

- ❍ Bladder Prolapse
- ❍ Difficulty Placing Urinary Catheter
- ❍ Kidney Disease
- ❍ Kidney Stones
- ❍ Night Time Urination
- ❍ Prostate Trouble
- ❍ Urinary Incontinence

CANCER

- ❍ List type _____

BONE FRACTURES

- ❍ List type _____

OTHER ILLNESSES NOT LISTED

- ❍ List type _____
- ❍ List type _____

Patient Signature: _____