

**Medical History Form**

**Patient Name:** \_\_\_\_\_ **Appointment Date:** \_\_\_\_\_ with Dr. \_\_\_\_\_

**Age:** \_\_\_\_\_ **Sex:** F M **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Dominant hand:** R L **Did you bring X-rays?** Y N

**Who is your primary physician? (Name):** \_\_\_\_\_ MD

**Who referred you to our office?** \_\_\_\_\_

**What body part is involved? (Please circle what applies in the table below)**

<b>Shoulder</b> Right/ Left	<b>Elbow</b> Right/ Left	<b>Wrist</b> Right/ Left	<b>Hand</b> Right/ Left	<b>Hip</b> Right/ Left	<b>Knee</b> Right/ Left	<b>Ankle</b> Right/ Left	<b>Foot</b> Right/ Left	<b>Neck</b>	<b>Back</b>
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In this section, check the **ONE LINE** which best describes how your problem started. Then answer the question below the box you checked. Use as much space to the right as needed.

**NO INJURY** (or onset was: Gradual or Sudden)  
Please indicate why do you think it started?

**INJURY** (Accident Sport (not Auto or Work)  
Date: \_\_\_\_\_ Please specify where and how it happened.  
What sport? \_\_\_\_\_ School? \_\_\_\_\_

**INJURY AT WORK** Date \_\_\_\_\_  
From a:  lift  twist  fall  bend  pull  reach

**WORK RELATED** (BUT NO INJURY)  
Date: \_\_\_\_\_ How did your job cause the problem?

**AUTO ACCIDENT** Date: \_\_\_\_\_ How was your car hit?


**On a scale of 0-10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10**

**What is the quality of the pain?** Please check all that apply:  Sharp  Dull  Stabbing  Throbbing  Aching  Burning

**The pain is:**  Constant  Comes and goes (intermittent).

**Does your pain wake you from your sleep?**  Yes  No

**Do you have:**  Swelling  Bruises  Numbness  Tingling  Weakness  Loss of control of bowel or bladder  
 Locking/catching  giving way

**Since my problem started, it is:**  Getting better  Getting worse  Unchanged

**What makes your symptoms worse?**  Standing  Walking  Lifting  Exercise  Twisting  Lying in Bed  
 Bending  Squatting  Kneeling  Stairs  Sitting  Coughing  Sneezing

**Which makes your symptoms better?**  Rest  Elevation  Ice  Heat  Other: \_\_\_\_\_