



name \_\_\_\_\_ age \_\_\_\_\_ birthdate \_\_\_\_\_ height \_\_\_\_\_ weight \_\_\_\_\_

consultation requested by: \_\_\_\_\_  worker's compensation case  legal case

Are you:  right handed  left handed  male  female occupation \_\_\_\_\_

Why are you here today? \_\_\_\_\_

When did the problem start? \_\_\_\_\_

How did it happen? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

For each, circle what **BEST** applies:

- The pain is: RARE INTERMITTENT CONSTANT
- The pain is: DULL SHARP ACHY THROBBING BURNING OTHER \_\_\_\_\_
- On a 0 to 10 severity scale (worst = 10) the pain is a: 0 1 2 3 4 5 6 7 8 9 10

Circle **ALL** that apply:

- associated symptoms: CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS INSTABILITY WEAKNESS TINGLING NIGHT PAIN OTHER \_\_\_\_\_

Have you ever experienced any injury to or symptoms involving this body part in the past?  Yes  No

If so, please provide details: \_\_\_\_\_

Have you had any treatment for this problem?  **NONE**  medication  therapy  splinting  injection  surgery

**Medical History:** Do you currently or have you ever had any of the following?  **NONE**

- anemia  arthritis  asthma / COPD  bleeding disorder  blood clots
- cancer  chronic pain syndrome  circulatory problems  depression  diabetes
- drug / alcohol problem  gout  fibromyalgia  heart disease  hepatitis
- high blood pressure  HIV / AIDS  kidney disease  osteoporosis  psychiatric illness
- pregnancy (current)  reflux / heartburn  seizures  sleep apnea/ CPAP  stomach ulcers
- stroke  thyroid problems  other / details \_\_\_\_\_

**Medications:**  **NONE**  additional sheet attached

Medication (include over the counter medicines and nutritional supplements)	Reason Used	Dose
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

**Medical Allergies** (rash, swelling, or shortness of breath):  **NONE**  penicillin  sulfa  latex  metals  tape  
 iodine (IV contrast)  shellfish  poultry products  other \_\_\_\_\_

**Medication Side Effects** (heartburn, nausea, vomiting):  **NONE**  anti-inflammatories  codeine  Percocet  
 Vicodin / Lortab  other \_\_\_\_\_

**Surgical History:**  **NONE.** Circle all that apply:  
 Eyes/ENT cataracts, vision correction, sleep apnea, tonsils, sinus surgery, thyroid, other \_\_\_\_\_  
 Heart bypass, valve replacement, stent, other \_\_\_\_\_  
 Lung resection, other \_\_\_\_\_  
 G I appendix, gall bladder, hernia, other \_\_\_\_\_  
 Gynecologic c-section, hysterectomy, tubal ligation, other \_\_\_\_\_  
 Urologic prostate, bladder, vasectomy, other \_\_\_\_\_  
 Orthopaedic joint replacement, arthroscopy, fracture surgery, spine, other \_\_\_\_\_  
 Vascular carotid, aneurysm, bypass, other \_\_\_\_\_  
 Neurosurgical aneurysm, tumor, craniotomy, other \_\_\_\_\_  
 Cancer skin, breast, other \_\_\_\_\_  
 Other \_\_\_\_\_

**Anesthesia Complications:**  **NONE.** If yes, explain: \_\_\_\_\_

**Other Current Symptoms:**  **NONE.** Circle all that apply:  
 yes  no Constitutional unexpected weight loss, weight gain, fever, chills, night sweats, fatigue \_\_\_\_\_  
 yes  no Eyes blurred / double vision, eye pain, redness, watering \_\_\_\_\_  
 yes  no ENT headache, difficulty swallowing, nose bleeds, ringing in ears, earaches \_\_\_\_\_  
 yes  no Cardiovascular chest pain, palpitations, fainting, murmurs \_\_\_\_\_  
 yes  no Respiratory shortness of breath, wheezing, coughing, painful breathing, snoring \_\_\_\_\_  
 yes  no Gastrointestinal heartburn, nausea, constipation, incontinence, diarrhea, bloody / black stools \_\_\_\_\_  
 yes  no Genitourinary urinary frequency, urgency, difficulty, pain, bleeding, incontinence \_\_\_\_\_  
 yes  no Musculoskeletal other joint pains, swelling, instability, stiffness, redness, heat, muscle pain \_\_\_\_\_  
 yes  no Skin skin changes, poor healing, rash, itching, redness \_\_\_\_\_  
 yes  no Neurological numbness / tingling, unsteady gait, dizziness, tremors, seizures \_\_\_\_\_  
 yes  no Psychological nervousness, anxiety, depression, hallucinations \_\_\_\_\_  
 yes  no Hematologic easy bleeding, bruising, \_\_\_\_\_  
 yes  no Endocrine excessive thirst or urination, heat / cold intolerance \_\_\_\_\_  
 yes  no Allergic reaction to foods or environment \_\_\_\_\_  
 yes  no Other \_\_\_\_\_

**Family History** (mother / father / siblings):  **NONE OF THE BELOW**  
 anesthesia complications \_\_\_\_\_  bleeding disorder \_\_\_\_\_  
 cancer \_\_\_\_\_  diabetes \_\_\_\_\_  
 gout \_\_\_\_\_  heart disease \_\_\_\_\_  
 malignant hyperthermia \_\_\_\_\_  arthritis \_\_\_\_\_  
 other \_\_\_\_\_

**Social History:**  
Marital Status:  single  married  divorced  widowed  separated  
Alcohol Use:  none  rare  daily  
Tobacco Use:  none  previous When quit? \_\_\_\_\_  current packs / day \_\_\_\_\_  
Recreational Drug Use:  none  previous  current drug \_\_\_\_\_ last used \_\_\_\_\_

**Additional information that you would like for us to know:** \_\_\_\_\_  
\_\_\_\_\_

patient or responsible party signature \_\_\_\_\_ date \_\_\_\_\_

physician review \_\_\_\_\_ date \_\_\_\_\_ updated \_\_\_\_\_