



**HEALTH HISTORY/
REVIEW OF SYSTEMS**

Name _____

Referring Physician _____ City/State of Referring Physician _____

In your own words, what is (are) your specific concern(s)? _____

AFFECTED AREA:

- | | | | |
|--------------------------------------|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Knee | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Wrist/hand | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Foot/ankle | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both |
| <input type="checkbox"/> Other _____ | | | |

Did you sustain an injury? No Yes If so, when? _____ Was it work related? No Yes

If work related, what is your current work status? _____

If not work related, During what activity? _____ How many re-injuries? _____

CURRENT MEDICATIONS (includes non-prescription products)

None

Drug	Dose	Frequency	Drug	Dose	Frequency
1. _____			2. _____		
3. _____			4. _____		
5. _____			6. _____		

ALLERGY TO MEDICATION: _____ None

PRESENT/PAST MEDICAL HISTORY (please check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Prostate disease | <input type="checkbox"/> Cervical spine disorder |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Lumbar spine disorder |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Bowel disease | <input type="checkbox"/> Severe headaches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer (past or present) | <input type="checkbox"/> Tuberculosis/TB |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia or other blood disease | <input type="checkbox"/> Muscle disease |
| <input type="checkbox"/> Hypoglycemia (low glucose) | <input type="checkbox"/> Blood clots/DVT | <input type="checkbox"/> Mental health problem |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stomach disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Chronic skin disease |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Bladder disease | <input type="checkbox"/> Nerve impairment | <input type="checkbox"/> Other _____ |

PERTINENT FAMILY MEDICAL HISTORY (cancer, heart disease, hypertension, etc):

HOSPITALIZATIONS (last 10 years):

None

Approximate Date Purpose

_____	_____
_____	_____
_____	_____

ORTHOPEDIC or NEUROLOGIC SURGERIES, FRACTURES (last 10 years):

None

Approximate Date Purpose

_____	_____
_____	_____
_____	_____

SPECIAL CONSIDERATIONS:

None

- | | |
|--|---|
| <input type="checkbox"/> Legally blind | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Hearing impaired | <input type="checkbox"/> Attempting pregnancy |
| <input type="checkbox"/> Need handicap facilities | <input type="checkbox"/> Smoker packs per day: _____ |
| <input type="checkbox"/> Substance abuse or addiction Describe: _____ | |
| <input type="checkbox"/> Alcohol abuse or addiction Describe: _____ | |

ACTIVITY LEVEL:

None

- Competitive athlete Well-trained/frequent sports Occasional sports

What would you like your physician/team to accomplish today? (please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Accurate diagnosis | <input type="checkbox"/> Alternative therapy plan (may include acupuncture, massage, manipulation) |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Disability info |
| <input type="checkbox"/> Surgery plan if necessary | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Healthy exercise plan | |
| <input type="checkbox"/> Nutritional plan | |
| <input type="checkbox"/> Physical therapy plan | |

PATIENT SIGNATURE _____ **DATE** _____

PARENT/GUARDIAN _____ **DATE** _____