Patient _____ Age_____ Occupation_____

Reason for Visit_____

Symptoms ☐ Pain ☐ Numbness ☐ Weakness ☐ Stiffness ☐ Other

Location ☐ Fingers ☐ Thumb ☐ Hand ☐ Wrist ☐ Forearm ☐ Elbow ☐ Arm ☐ Shoulder ☐ Chest ☐ Neck ☐ Toes ☐ Foot ☐ Ankle ☐ Leg ☐ Knee ☐ Thigh ☐ Hip ☐ Upper back ☐ Lower back ☐ Other

Severity (on a scale from 1 to 10) _____ Duration or Date of Onset_____

Timing (constant, intermittent, etc.)_____ Modifying Factors _____

Previous Injury (recent or distant)_____ Associated Symptoms_____

Previous Treatment For this problem

- ☐ **Medication** _____
- ☐ **Physical Therapy** **duration_____ frequency_____/week**
- ☐ **Injections** **location _____ dates _____**
- ☐ **Splinting or Casting** **type_____ dates_____**
- ☐ **Surgery** **type_____ dates_____**
  type_____ dates_____

Past Medical History

Prior & Current Illnesses and Injuries _____

Prior Surgeries & Hospitalizations _____

Current Medications & Dosages _____

Allergies to Any Medications or Foods _____

Family History

Parents Ages & Health(if deceased, age at death & cause)_____

Siblings Ages & Health(if deceased, age at death & cause)_____

Do you have any relatives with: ☐ **Arthritis** ☐ **Heart Disease** ☐ **High Blood Pressure** ☐ **Diabetes** ☐ **Muscle Disease** ☐ **Other_____**

Social History

Marital Status ☐ **Single** ☐ **Married** **Children (Ages)_____**

Alcohol Use (amount&type) _____Drug Use(amount&type)_____

Tobacco Use_____packs per day X_____year

PLEASE CONTINUE - - >