

Today's Date: ___/___/___

Welcome To Physicians Sports and Injury Center, LLC

Name _____
Last First MI

Nature of Complaint

Cause of Condition

What caused your symptoms? Auto Accident Work Accident Other/Unknown: _____

Personal Information

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Email: _____

Birth Date: ___/___/___ Social Security: _____-____-_____ Age: _____

Gender: Male Female Race: _____ Ethnicity: _____

Marital Status: Single Married Divorced Widowed Separated

Occupation: _____ May we call you at work? Yes No Work Phone (____) _____

Emergency Contact: _____ Relationship to patient: _____

Phone number: Home: (____) _____ Work: (____) _____ Cell: (____) _____

PERSONAL HEALTH HISTORY

PLACE A "C" NEXT TO ALL SYMPTOMS/PROBLEMS YOU HAVE CURRENTLY
AND PLACE A "P" NEXT TO ALL SYMPTOMS/PROBLEMS YOU HAVE HAD IN A PAST

I have not had, nor do I presently have, any of the following symptoms.

- | | | | |
|--|---|--|---|
| <p>___ Burning, tingling, or numbness into the shoulders, arms, or hands (upper extremities)</p> <p>___ Burning, tingling, or numbness into the hips, legs, or feet (lower extremities)</p> <p>___ Recent loss or blurring of vision</p> <p>___ Cancer:
Type(s): _____
Date diagnosed: ___/___/___</p> <p>___ Diabetes:
___ Type I
___ Type II (adult onset)</p> <p>___ Abdominal pain</p> <p>___ Allergies
Type: _____</p> <p>___ Angina</p> <p>___ Back pain</p> <p>___ Blurred vision</p> <p>___ Chemical dependency</p> <p>___ Chest pain</p> <p>___ Chronic back problems</p> <p>___ Cold feet</p> <p>___ Alcoholism</p> <p>___ Anemia</p> <p>___ Anorexia</p> <p>___ Appendicitis</p> <p>___ Arteriosclerosis</p> <p>___ Arthritis</p> <p>___ Asthma</p> <p>___ Bleeding disorders</p> <p>___ Blindness</p> <p>___ Bulimia</p> <p>___ Cancer</p> <p>___ Cataracts</p> <p>___ Chicken Pox</p> | <p>___ Condition aggravated by coughing, sneezing, or grunting</p> <p>___ Loss of sexual function</p> <p>___ Recent onset of:
___ Urinary retention
___ Increased urinary frequency
___ Inability to control bladder</p> <p>___ Constant pain unrelated to movement</p> <p>___ Night pain unrelated to movement</p> <p>___ Unexplained weight loss greater than 10 lbs.</p> <p>___ History of malaise/generalized weakness</p> <p>___ History of fever or chills</p> <p>___ Cold sweats</p> <p>___ Constipation</p> <p>___ Depression</p> <p>___ Dermatitis</p> <p>___ Digestive problems</p> <p>___ Dizziness</p> <p>___ Fainting</p> <p>___ Fatigue</p> <p>___ Hair loss</p> <p>___ Headaches</p> <p>___ Heart attacks</p> <p>___ Hormone replacement</p> <p>___ Jaw problems</p> <p>___ Chronic lung disease
___ Bronchitis
___ Emphysema</p> <p>___ Congestive heart failure</p> <p>___ Connective tissue disease
Type: _____
Date diagnosed: ___/___/___</p> <p>___ Deafness or reduced hearing</p> <p>___ Drug/alcohol dependency</p> <p>___ Epilepsy</p> <p>___ Fibromyalgia</p> <p>___ Fractures</p> <p>___ Gall Bladder Problems</p> <p>___ Glaucoma</p> <p>___ Goiter</p> | <p>___ Joint swelling</p> <p>___ Kidney stones</p> <p>___ Loss of smell</p> <p>___ Loss of memory</p> <p>___ Loss of taste</p> <p>___ Menstrual cramps</p> <p>___ Migraines</p> <p>___ Miscarriage</p> <p>___ Muscular incoordination</p> <p>___ Nausea</p> <p>___ Nervousness</p> <p>___ Painful urination</p> <p>___ Pinched nerve</p> <p>___ Gout</p> <p>___ Heart Disease</p> <p>___ Hepatitis</p> <p>___ Hernia</p> <p>___ Herniated disc</p> <p>___ Herpes</p> <p>___ High Blood Pressure</p> <p>___ High Cholesterol</p> <p>___ HIV/AIDS</p> <p>___ Hypertension</p> <p>___ Kidney Disease</p> <p>___ Liver Disease</p> <p>___ Low Blood Pressure</p> <p>___ Low Blood Sugar</p> <p>___ Measles</p> | <p>___ Osteoporosis</p> <p>___ Bacterial infection
Date it began: ___/___/___</p> <p>___ Abdominal pain</p> <p>___ Blood in urine</p> <p>___ Rectal bleeding</p> <p>___ Hemorrhoids</p> <p>___ Urethral discharge</p> <p>___ Prolonged steroid use</p> <p>___ IV drug abuse</p> <p>___ PMS</p> <p>___ Prostate problems</p> <p>___ Ringing/buzzing in the ears</p> <p>___ Shortness of breath</p> <p>___ Sleeping difficulties</p> <p>___ Stomach problems</p> <p>___ Tension</p> <p>___ Tooth Pain</p> <p>___ Ulcer/gastrointestinal bleeding</p> <p>___ Unexplained excessive thirst</p> <p>___ Unexplained loss of appetite</p> <p>___ Vaginal infections</p> <p>___ Menopause</p> <p>___ Mononucleosis</p> <p>___ Multiple Sclerosis</p> <p>___ Mumps</p> <p>___ Pacemaker</p> <p>___ Parkinson's Disease</p> <p>___ Pneumonia</p> <p>___ Polio</p> <p>___ Pregnancy</p> <p>___ Prostate Disease</p> <p>___ Prosthesis</p> <p>___ Psychiatric Care</p> <p>___ Psoriasis</p> <p>___ Rheumatic fever</p> <p>___ Rheumatoid arthritis</p> <p>___ Scarlet fever</p> <p>___ Sciatica</p> <p>___ Scoliosis</p> <p>___ Sinus problems</p> <p>___ SLE (Lupus)</p> <p>___ Spinal Disc Disorder</p> <p>___ STDs (venereal, etc.)</p> <p>___ Stroke</p> <p>___ Tendonitis</p> <p>___ Thyroid Disorder</p> <p>___ Tumor(s)</p> <p>___ Visual disturbances</p> <p>___ Whooping cough</p> |
|--|---|--|---|

Please tell us about any major injuries, hospitalizations, serious illnesses or surgeries:

Year	Reason	Hospital
Outcome		

List your prescribed medications, over-the-counter medications, herbs, vitamins and inhalers:

Product	Reason	Dosage (Example: 500mg)	Frequency (Example: 2x/day)	Is it helping?

DOCTOR SIGNATURE: _____

PATIENT SIGNATURE: _____

Please provide details of any known allergies. (eg., latex, medications, foods)

Allergy	Reaction

HEALTH HABITS

EXERCISE: How often do you exercise? Never Rarely Occasionally Moderately Regularly

Type of exercise: _____

If you exercise, what is the intensity? Light Moderate Strenuous

INTERESTS/HOBBIES: What interests, hobbies, or activities do you enjoy? _____

HABITS: Do you drink alcohol? Never Once a week Several times a week Once daily Several times per day

Tobacco Use:

Cigarettes: Never Used in the past Less than ½ pack/day ½ pack/day 1 pack/day 2 packs/day More than 2 packs/day

Chewing tobacco: Never Used in the past Occasionally Often

Cigars: Never Used in the past Occasionally Often

For how many years have you used tobacco products? _____

If you have quit smoking, when did you quit? _____ months ago / years ago (please circle one)

DIET/NUTRITION: Are you dieting currently? Yes No Is this a physician prescribed medical diet? Yes No

How many meals do you eat on average every day? _____

Do you drink water daily? 0-2 glasses 2-4 glasses 4-6 glasses 6-8 glasses 8-10 glasses

Do you drink beverages containing caffeine? Never Once a week Several times/week Once daily Several times per day

Do you eat refined sugar? Never Once a week Several times per week Once daily Several times per day

Do you consume dairy products? Never Once a week Several times per week Once daily Several times per day

Do you eat wheat products? Never Once a week Several times per week Once daily Several times per day

SLEEP PATTERNS:

Does your complaint disrupt your sleep? Yes No

How do you rate your quality of sleep?: Perfect 1 2 3 4 5 6 7 8 9 10 Terrible

What position do you sleep in? _____

Do you sleep with a pillow? Yes No If Yes, how many? _____

STRESS FACTORS: Please rate your stress management strategies: Perfect 1 2 3 4 5 6 7 8 9 10 Terrible

Please rate your daily stress level : None 1 2 3 4 5 6 7 8 9 10 Terrible

PREGANANCY/CHILDREN: # of Pregnancies _____ # Birth Children _____

DOCTOR SIGNATURE: _____

PATIENT SIGNATURE: _____

Please check the boxes below to indicate how this condition has affected the following aspects of your life:

	Severely	Moderately	Mildly	Not at all
Quality of work				
Ability to do household chores				
Social life				
Family life				
Recreational activities				
Quality of sleep				

Has this condition affected your life in any other way? Yes No **If Yes, how:** _____

FAMILY HEALTH HISTORY

Please help us to identify your potential health risks by placing a check in any column that applies to you or your blood relatives.

Condition / Body System	Self	Grandparent	Parent	Sibling	Child	None
Aids / HIV						
Arthritis						
Bleeding disorders						
Cancer						
Endocrine / glandular (diabetes, thyroid)						
Hepatitis						
Immune						
Stroke / TIA						
Circulatory Problems (blood vessels, heart)						
Ear, Nose, Throat						
Heart Problems						
High blood pressure						
Neurological (brain, nerves)						
Gastrointestinal (stomach, intestines)						
Muscle / Joint / Bone						
Genitourinary (urinary, kidney, prostate)						
Psychological						
Respiratory (lung, breathing)						
Skin						

WORK STATUS

Work schedule: Full Time Part Time **Hours per day:** _____ **Typical overtime hours:** _____ **Average hours per week:** _____

Has this condition caused you to miss work? Yes No **(IF "NO" PLEASE SKIP THIS SECTION)**

Date you were first off work ___/___/___ **Returned to work?** Yes Limited hours only No **Date of return:** ___/___/___

(Ex: MD, chiropractor, neurologist)

Returned to work with recommendation from _____ **Returned without recommendation**

Can you perform your usual work duties? Yes No **Is alternative work available to you?** Yes No

Has a physician placed you on work restriction/disability? (IF NO, PLEASE SKIP THIS SECTION)

Yes, **TOTAL** restriction/disability Yes, **PARTIAL** restriction

By whom? (List doctor's name and specialty) _____

Please list your work restrictions _____

Return to regular work duties: Exact Date: ___/___/___ **Approx. Date :** ___/___/___

Date for return to regular work is unknown.

DOCTOR SIGNATURE: _____

PATIENT SIGNATURE: _____