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:** _____ **Ethnictiy:** _____

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.

_____ Burning, tingling, or numbness into the shoulders, arms, or hands (upper extremities)
_____ Burning, tingling, or numbness into the hips, legs, or feet (lower extremities)
_____ Recent loss or blurring of vision
_____ Cancer:
Type(s): _____
Date diagnosed: ____/____/_____
_____ Diabetes:
___ Type I
___ Type II (adult onset)

___ Condition aggravated by coughing, sneezing, or grunting
___ Loss of sexual function
___ Recent onset of:
___ Urinary retention
___ Increased urinary frequency
___ Inability to control bladder
___ Constant pain unrelated to movement
___ Night pain unrelated to movement
___ Unexplained weight loss greater than 10 lbs.
___ History of malaise/generalized weakness
___ History of fever or chills

___ Osteoporosis
___ Bacterial infection
Date it began: ___/___/___
___ Abdominal pain
___ Blood in urine
___ Rectal bleeding
___ Hemorrhoids
___ Urethral discharge
___ Prolonged steroid use
___ IV drug abuse

___ Abdominal pain
___ Allergies
Type:
_____
_____
_____
___ Angina
___ Back pain
___ Blurred vision
___ Chemical dependency
___ Chest pain
___ Chronic back problems
___ Cold feet
___ Cold sweats
___ Constipation
___ Depression
___ Dermatitis
___ Digestive problems
___ Dizziness
___ Fainting
___ Fatigue
___ Hair loss
___ Headaches
___ Heart attacks
___ Hormone replacement
___ Jaw problems
___ Joint swelling
___ Kidney stones
___ Loss of smell
___ Loss of memory
___ Loss of taste
___ Menstrual cramps
___ Migraines
___ Miscarriage
___ Muscular incoordination
___ Nausea
___ Nervousness
___ Painful urination
___ Pinched nerve
___ PMS
___ Prostate problems
___ Ringing/buzzing in the ears
___ Shortness of breath
___ Sleeping difficulties
___ Stomach problems
___ Tension
___ Tooth Pain
___ Ulcer/gastrointestinal bleeding
___ Unexplained excessive thirst
___ Unexplained loss of appetite
___ Vaginal infections

___ Alcoholism
___ Anemia
___ Anorexia
___ Appendicitis
___ Arteriosclerosis
___ Arthritis
___ Asthma
___ Bleeding disorders
___ Blindness
___ Bulimia
___ Cancer
___ Cataracts
___ Chicken Pox
___ Chronic lung disease
___ Bronchitis
___ Emphysema
___ Congestive heart failure
___ Connective tissue disease
___ Type: _____
___ Date diagnosed: ___/___/___
___ Deafness or reduced hearing
___ Drug/alcohol dependency
___ Epilepsy
___ Fibromyalgia
___ Fractures
___ Gall Bladder Problems
___ Glaucoma
___ Goiter
___ Gout
___ Heart Disease
___ Hepatitis
___ Hernia
___ Herniated disc
___ Herpes
___ High Blood Pressure
___ High Cholesterol
___ HIV/AIDS
___ Hypertension
___ Kidney Disease
___ Liver Disease
___ Low Blood Pressure
___ Low Blood Sugar
___ Measles
___ Menopause
___ Mononucleosis
___ Multiple Sclerosis
___ Mumps
___ Pacemaker
___ Parkinson's Disease
___ Pneumonia
___ Polio
___ Pregnancy
___ Prostate Disease
___ Prosthesis
___ Psychiatric Care
___ Psoriasis
___ Rheumatic fever
___ Rheumatoid arthritis
___ Scarlet fever
___ Sciatica
___ Scoliosis
___ Sinus problems
___ SLE (Lupus)
___ Spinal Disc Disorder
___ STDs (venereal, etc.)
___ Stroke
___ Tendonitis
___ Thyroid Disorder
___ Tumor(s)
___ Visual disturbances
___ Whooping cough

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: _____