Musculoskeletal New Patient History ***Date:***_____

Patients name: _____ Age:_____ DOB: _____

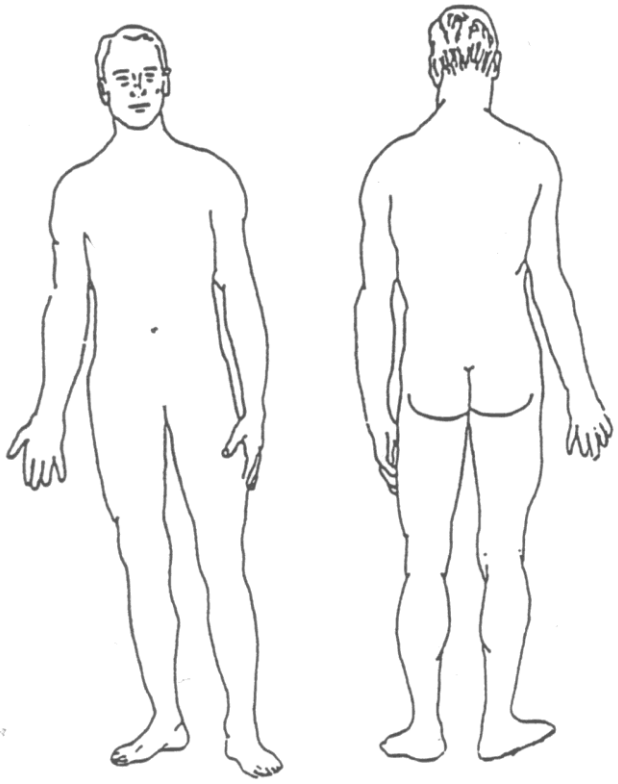
Chief Complaint:_____

When and how did the problem occur?_____

Was this a result of an acute injury or accident?_____

_____

Problem Diagram: (Please mark the areas on the diagram where you are experiencing difficulty.)



Leave Blank

If you have pain please describe the pain sensation. (Check those that apply)

Aching ☐ *Tightness* ☐ *Pins & Needles* ☐ *Burning* ☐ *Stabbing/Sharp* ☐
Shooting ☐ *Twisting* ☐ *Pressure* ☐ *Numbness/Tingling* ☐

When during the day do you have your pain? _____

What makes your pain worse? _____

What makes your pain better?_____

What daily activities does this problem affect? _____

Have you received any special testing or procedures for this problem? (Check below)

CT Scan ☐ MRI ☐ EMG ☐ X-rays ☐ Injections ☐ Surgery ☐

Review of Systems

(Please select any symptoms or findings below that you have experienced recently)

Constitutional	None	None	None		
Eyes	None	None			
ENMT	None	None	None	None	
Cardiovascular	None	None	None		
Respiratory	None	None	None		
Gastrointestinal	None	None	None		
Genitourinary	None	None	None		
Musculoskeletal	None	None	None		
Skin	None	None	None	None	None
Neurological	None	None	None	None	None
Psychological	None	None	None	None	
Endocrine	None	None	None		
Hematology	None	None	None		

Hand Dominance Right ☐ Left ☐

Past Medical History

Allergies to medications/foods/chemicals? _____

Medication & Supplements List

Medication Dosage How often Taken_____

_____

_____

_____

Medication & Supplements List

Medication **Dosage** **How often Taken**

Supplements **Dosage** **How often Taken**

Medical Illnesses (that you have been Diagnosed with: check those that apply)

Diabetes ☐
Asthma ☐
High Blood Pressure ☐
Heart Attack ☐
Sleep Disorders ☐
Stomack Ulcers ☐
Stroke ☐
Cancer ☐
Heart Murmur ☐
HIV/AIDS ☐
Hepatitis ☐
Osteoarthritis ☐
Rheumatoid Arthritis ☐
Bowel/Bladder Incontinence ☐
Broken Bones ☐
Anemia ☐
Seizures ☐
Hyper/Hypo Thyroid ☐
Osteoporosis ☐
Deep Vein Thrombosis ☐

*Other_____

Injuries: _____
(Include broken bones, concussion, motor vehicle accidents, falls etc.)

Surgeries: 1)_____ Date:_____

2)_____ Date:_____

3) _____ Date:_____

Family History of Medical Problems: (Check those that apply)

Arthritis ☐ *Back Problems* ☐ *Heart Problems* ☐ *Diabetes* ☐ *Cancer* ☐

*Other_____

Social History

Do you exercise? Yes ☐ No ☐

What type? _____

How often and how long? _____

Occupation _____

Hobbies/Interests _____

Do you use Tobacco, Alcohol, or Drugs? If yes, then how often? _____