Musculoskeletal New Patient History *Date:*_____

Patients name: _____ Age:_____ DOB: _____

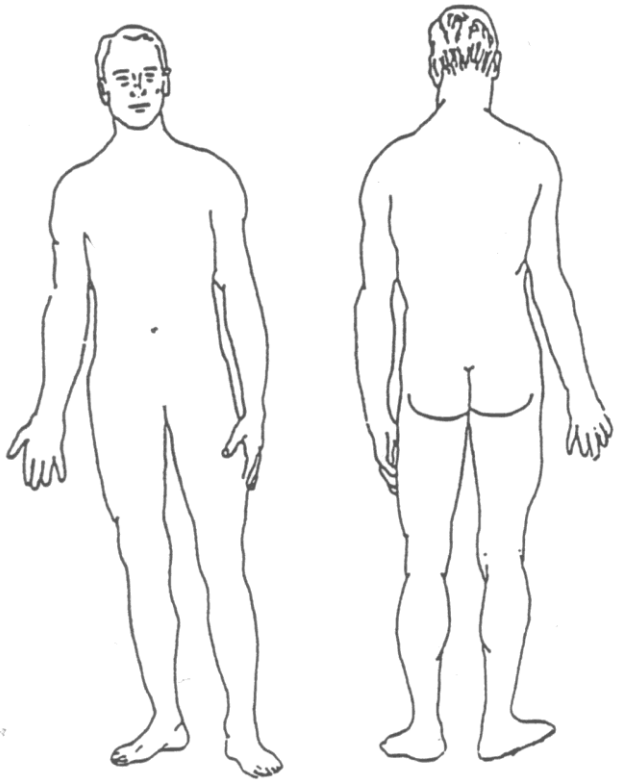
Chief Complaint:_____

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 : Weight Change ☐ Weakness ☐ Fatigue ☐ Fever ☐ Nausea ☐

Eyes: Vision Problems ☐ Double Vision ☐

ENMT: Hearing Problems ☐ Dizziness ☐ Sinus Trouble ☐ Sore Throat ☐ Ringing Ears ☐

Cardiovascular: Shortness of Breath ☐ Chest Pain ☐ Leg Swelling ☐ Increased Blood Pressure ☐

Respiratory: Cough ☐ Coughing Up Blood ☐ Wheezing ☐ Asthma ☐

Gastrointestinal: Trouble Swallowing ☐ Heartburn ☐ Vomiting ☐ Diarrhea ☐
Blood/Black Tar Stools ☐

Genitourinary: Pain with Urination ☐ Blood in Urine ☐ Urgency ☐ Incontinence ☐

Musculoskeletal: Joint Pain/Stiffness ☐ Cramps ☐ Weakness ☐ Loss of Motion ☐

Skin: Rash ☐ Lumps ☐ Itching ☐ Dryness ☐ Hair Changes ☐ Nail Changes ☐

Neurological: Fainting ☐ Blackouts ☐ Seizures ☐ Paralysis ☐ Weakness ☐ Numbness ☐
Memory Loss ☐ Headaches ☐

Psychological: Nervousness ☐ Tension ☐ Mood Changes ☐ Depression ☐ Anxiety ☐

Endocrine: Heat or Cold Intolerance ☐ Sweating ☐ Thirst ☐ Changes with Hunger ☐

Hematology: Bruising ☐ Bleeding ☐ Transfusion Reactions ☐

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:_____

Dental Work: ☐ Fillings ☐ Root Canals ☐ Other: _____

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? _____