

NAME: _____ TODAY'S DATE: _____
 SEX: _____ DATE OF BIRTH: _____ SS #: _____
 ADDRESS: _____
 HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____
 EMAIL: _____ EMPLOYERS NAME/ADDRESS: _____
 ARE YOU PRESENTLY WORKING? Yes / No _____
 IF NO, WHEN DID YOU STOP WORKING: _____ EMPLOYERS PHONE #: _____
 Referring Physician: _____

Name	Address	Phone#
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Do you want this consult sent to your referring physician? Yes / No

CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS:

Is this a new injury that you have not been seen for before? Yes / No
 Body part injured: () Left () Right _____
 Date of injury / accident / onset: _____ Cause: Sports / Work / MVA / Other
 How did the injury occur? _____
 How does it affect/bother you? _____
 Pain at rest: (No Pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Worst pain imaginable)
 Pain at activity: (No Pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Worst pain imaginable)
 Does anything help decrease your pain? _____
 If you were or / are unable to work / Play, list the dates of the disability: _____ to _____

MEDICAL HISTORY:

Medical Problems? _____ Drug Allergies? _____
 Current Medication _____
 Previous Hospitalizations & Surgical Procedures: _____

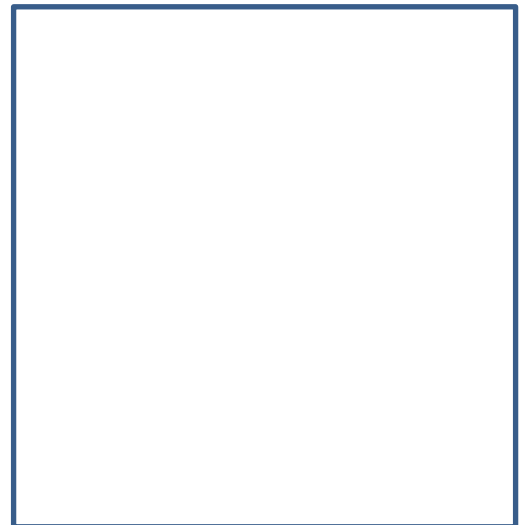
FAMILY MEDICAL HISTORY: (Illness affecting patient's immediate family) _____

SOCIAL HISTORY: Married / Single / Divorced / Widowed / Other _____ **ALCOHOL USE:** Occasional / Daily / Heavy/ None

TOBACCO USE: Yes / No Type: _____ Packs Per Day: _____ Years Smoked: _____ Recreational Drug: Yes / No Type _____

REVIEW OF SYSTEMS: (Check all that apply)

- | | | |
|--|---|--|
| <p><u>GENERAL</u>
 <input type="checkbox"/> weight change
 <input type="checkbox"/> Fever or Chills
 <input type="checkbox"/> Aids / HIV
 <input type="checkbox"/> Night Sweats
 <input type="checkbox"/> Bleeding
 <input type="checkbox"/> Lumps or Masses
 <input type="checkbox"/> Dizziness or Fainting
 <input type="checkbox"/> Diabetes Mellitus
 <input type="checkbox"/> Thyroid Problems
 <input type="checkbox"/> Cancer</p> <p><u>EAR-EYE-NOSE-THROAT</u>
 <input type="checkbox"/> Visual Change
 <input type="checkbox"/> Hearing Change
 <input type="checkbox"/> Tinnitus
 <input type="checkbox"/> Bleeding Gums</p> <p><u>MUSCULOSKELETAL</u>
 <input type="checkbox"/> Backache
 <input type="checkbox"/> Joint Pain
 <input type="checkbox"/> Joint Swelling</p> | <p><u>GASTROINTESTINAL</u>
 <input type="checkbox"/> Difficulty Swallowing
 <input type="checkbox"/> Jaundice
 <input type="checkbox"/> Hepatitis
 <input type="checkbox"/> Reflux
 <input type="checkbox"/> Ulcer</p> <p><u>CARDIOVASCULAR</u>
 <input type="checkbox"/> Chest Pain
 <input type="checkbox"/> Heart Disease
 <input type="checkbox"/> High Blood Pressure
 <input type="checkbox"/> Mitral Valve Prolapse
 <input type="checkbox"/> Thrombophlebitis</p> <p><u>RESPIRATORY</u>
 <input type="checkbox"/> Cough/Sputum
 <input type="checkbox"/> Tuberculosis
 <input type="checkbox"/> Shortness of Breath
 <input type="checkbox"/> Asthma
 <input type="checkbox"/> Emphysema</p> <p><u>OTHER ILLNESS:</u> _____
 <input type="checkbox"/> All Systems Reviewed & Negative</p> | <p><u>GENITOURINARY</u>
 <input type="checkbox"/> Urinary Infection
 <input type="checkbox"/> Incontinence
 <input type="checkbox"/> Urinary Frequency
 <input type="checkbox"/> Venereal Disease
 <input type="checkbox"/> Menopause</p> <p><u>NEUROLOGIC</u>
 <input type="checkbox"/> Seizures
 <input type="checkbox"/> Numbness
 <input type="checkbox"/> Weakness</p> <p><u>PSYCHOLOGICAL</u>
 <input type="checkbox"/> Depression
 <input type="checkbox"/> Bipolar
 <input type="checkbox"/> ADD/ADHA
 <input type="checkbox"/> Other</p> <p><u>SKIN</u>
 <input type="checkbox"/> Itching or Rash</p> |
|--|---|--|



PATIENT/GUARDIAN SIGNATURE

DATE

** PHYSICIAN'S SIGNATURE **

DATE