



Patient's Name: _____ Age: _____ Date: _____ Page 1

New Patient History Form

Is this a Workers Compensation injury/Illness? Yes No if yes, please complete the following:

CLAIM NUMBER: _____ DATE OF INJURY/ILLNESS: ____/____/____

CLAIMS MANAGER: _____ EMPLOYER/JOB TITLE: _____

Did a Motor Vehicle Accident cause your injuries? Yes No Date of Accident: ____/____/____

1. Chief Complaint: (reason for visit): _____

2. Referring Physician: _____ Address: _____ Phone: _____

3. Family Physician: _____ Address: _____ Phone: _____

4. History of Present Illness

History From: Patient Name and Relationship to patient, if other than patient: _____

Do you write with your: left hand or right hand?

5. Do you have pain? Yes No If you have no symptoms of pain please go to question #6.

Where is the one place it hurts the most? _____

What kind of pain do you have? aching stabbing throbbing sharp dull burning

On a scale of 1-10 (1=mild, 10=intense) describe your pain: 1 2 3 4 5 6 7 8 9 10 (circle the number that applies)

How long have you had these symptoms? _____

How did the symptoms start? or What brought the symptoms on? _____

Are these symptoms always there or do they come and go? Always There Comes and Goes

What makes the symptoms worse? _____

What makes the symptoms better? _____

What are your other symptoms associated with your pain? _____

Do you have numbness? or tingling? Where? _____

Do you have and weakness? Where? _____

Does the pain radiate to other parts of your body? Where? _____

What treatment(s) have you tried? Medications Physical Therapy Rest Pain Clinic Other: _____



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<p align="center">6. Past Medical History</p> <p align="center">Circle only the items that apply.</p>	<p align="center">7. Prior Surgical History</p> <p align="center">Please circle all that apply and provide the date of the surgery.</p>
Anesthesia Complications (please describe)	Appendectomy
Anxiety Disorder	Breast Surgery
Bleeding Disorder	Carotid Artery Surgery
Cancer (where?)	Carpel Tunnel Surgery (left or right)
Carpel Tunnel (left or right)	Caesarian Section Surgery
Cervical Neck Pain	Cataract Surgery
Mid Thoracic Back Pain	Colon Surgery
Low Lumbar Back Pain	Cranial Surgery
Diabetes	D&C
Depression	Gallbladder Surgery
Gastric Reflux Disease (GERD)	Heart Bypass Surgery
Gastric Ulcers	Heart Stents
Heart Attack	Hemorrhoidectomy
Heart Disease	Hip Replacement Surgery (left or right)
Hepatitis	Hysterectomy
High Cholesterol	Knee Surgery (left or right)
High Blood Pressure	Low Back Surgery
Kidney Disease	Neck Surgery
Liver Disease	Shoulder Surgery (left or right)
Lung Disease	Thyroid Surgery
Migraine Headaches	Tubal Ligation
Osteoarthritis	Tonsillectomy
Rheumatoid Arthritis	Please list others not listed above:
Thyroid Disease	
Please list others not listed above:	



Patient's Name: _____ Age: _____ Date: _____ Page 3

8. Family History– Please answer each item. If you do not know any family members with the illness, leave all boxes unchecked.

Cancer
 Father
 Mother
 Brother
 Sister
 Child
 Grandparent

High Blood Pressure
 Father
 Mother
 Brother
 Sister
 Child
 Grandparent

Stroke
 Father
 Mother
 Brother
 Sister
 Child
 Grandparent

Diabetes
 Father
 Mother
 Brother
 Sister
 Child
 Grandparent

Spine Problems
 Father
 Mother
 Brother
 Sister
 Child
 Grandparent

Heart Disease
 Father
 Mother
 Brother
 Sister
 Child
 Grandparent

Psychiatric
 Father
 Mother
 Brother
 Sister
 Child
 Grandparent

Aneurysm
 Father
 Mother
 Brother
 Sister
 Child
 Grandparent

9. Social History– Please answer all that apply

Marital Status: married divorced single separated widowed

Employment Status: employed as a _____

unemployed since _____ disabled since _____ retired since/type of work? _____

Tobacco Use: Never has used Tobacco Currently is a smoker Currently uses smokeless tobacco
 Currently smokes cigars Was a previous smoker and quit in _____

Alcohol Use: Does not consume alcohol Consumes alcohol socially Consumes alcohol daily

Illegal Drug Use: Does not use drugs Uses the following: marijuana cocaine heroine amphetamines
 barbiturates other: _____



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10. Current Medications– List all medications you are currently taking, along with the dosages and how often you take the med.
Include all prescriptions, over the counter meds, herbal supplements and vitamins.

Medication	Dose	Take how many per day?
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11. Allergies– List all allergies to medication you have.

Please describe what type of reaction you have
(hives, rash, upset stomach, etc).

Do you have any food allergies? Please List

Are you allergic to:

Tape?

Latex?

X-ray Dyes?

Other?



Patient's Name:

12. Review of Systems– Please mark all that apply for recent symptoms, if none please leave blank.

- General: fever
 chills
 appetite loss
 weight loss
 fatigue

- Head: history of trauma
 frequent headaches
 visual changes
 decreased facial sensation
 loss of muscle control to the face

- Eyes: vision loss in 1 eye
 vision loss in both eyes
 double vision
 blurred vision
 use of contacts
 use of glasses

- Gastrointestinal: indigestion
 constipation
 incontinence of stool
 blood present in stool

- Urinary: increased frequency
 hesitancy
 urinary incontinence
 blood present in urine
 history of kidney stones

- Neurological: loss of sensation
 numbness
 tingling
 tremors
 weakness
 fainting
 confusion
 seizures

- Musculoskeletal: weakness
 joint pain
 decreased range of motion
 history of arthritis
 fracture

- ENT recent loss of hearing
 feelings of imbalance
 frequent nose bleeds
 persistent clear drainage
 loss of smell
 difficulty swallowing
 change in taste

- Respiratory: shortness of breath
 coughing up blood
 emphysema
 tuberculosis

- Cardiovascular: chest pain
 heart murmur
 swelling in the arms
 swelling in the legs

- Endocrine: thyroid problems
 history of diabetes
 excessive thirst

- Hematological: history of anemia
 easy bruising
 history of blood transfusion

- Psychiatric: mood swings
 feelings of depression

- Skin: rash
 itching
 dryness
 suspicious lesion

- Allergic/Immunologic: hay fever
 persistent infections

Patient's Name: _____

13. Vitals: Height: _____ Weight: _____ BP: ____/____ Pulse Rate: _____

14. Diagnostic Studies:

CT Scan Type/Date of films: _____ Place of testing: _____

MRI Type/Date of films: _____ Place of testing: _____

X-Ray Type/Date of films: _____ Place of testing: _____

EEG Type/Date of films: _____ Place of testing: _____

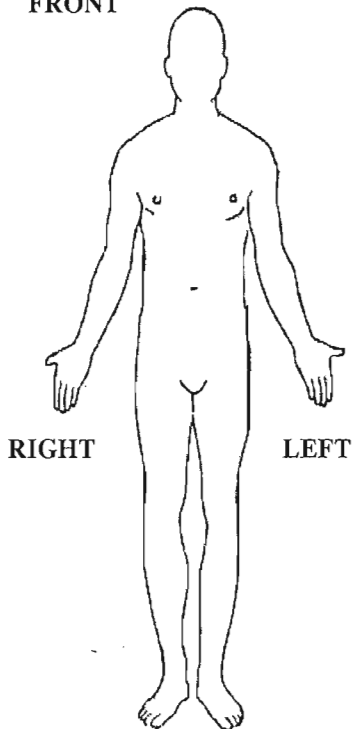
EMG Type/Date of films: _____ Place of testing: _____

15. Using the symbols given below, mark the areas on your body where you feel the described sensations.
Include all affected areas.

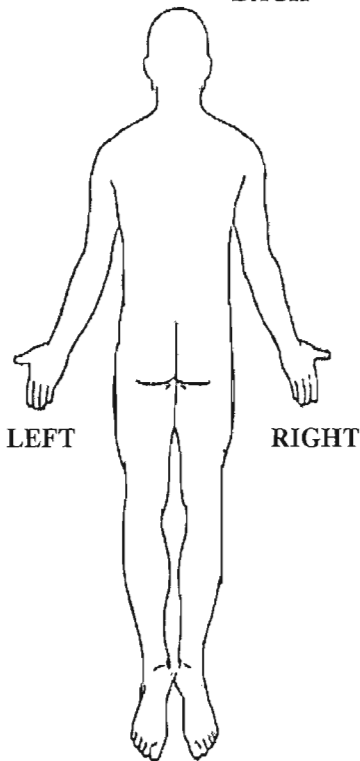
/// stabbing	xxx burning	ooo pins and needles	+++ aching	=== numbness	... other
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DRAW IN YOUR FACE

FRONT



BACK



Do you get pain at the top of your Tailbone/top of head?
 Yes No

Does your whole leg/arms ever become painful?
 Yes No

Does your whole leg/arms ever become numb?
 Yes No

Does your leg/arms ever give way?
 Yes No

In the past year have you had any spells with very little pain?
 Yes No

Have you had any intolerance/reaction to your treatment?
 Yes No

Have you had an emergency room visit with back/neck trouble since it started?
 Yes No

The information on this form provided by the patient and or family members was personally reviewed and or amended by me.

Reviewed by: _____ Date: _____