PATIENT INFORMATION

NAME: _____ DATE: _____

OCCUPATION: _____ AGE : _____

ARE YOU RIGHT OR LEFT HANDED? _____HEIGHT:_____WEIGHT:_____

DESIRED SPORTS ACTIVITIES: _____

WHAT BODY PART ARE YOU BEING SEEN FOR: _____

RIGHT – LEFT

WHEN DID IT START? _____

DESCRIPTION OF PROBLEM: _____

_____

SYMPTOMS	YES	NO
STIFFNESS		
SWELLING		
WEAKNESS		
CLICKING, CATCHING, LOCKING		
GRINDING		
GOES OUT		
NUMBNESS		
NECK OR BACK PAIN		
SIMILAR PAST PROBLEMS		
PREVIOUS SURGERY ON PROBLEM AREA		

GENERAL MEDICAL HISTORY	YES	NO
ARTHRITIS		
HEART TROUBLE		
LUNG/RESPIRATORY PROBLEMS		
HIGH BLOOD PRESSURE		
STROKE/ CVA		
DIABETES		
THYROID DISEASE		
KIDNEY OR LIVER PROBLEMS		
NEUROLOGICAL DISORDERS		
BLEEDING PROBLEMS		
PEPTIC ULCER DISEASE		
PROBLEMS TAKING ANTI-INFLAMMATORIES		
CANCER OR TUMOR		
DO YOU SMOKE? (IF SO, HOW MUCH)		
DO YOU DRINK ALCOHOL? (IF SO, HOW MUCH)		
ANY OTHER MEDICAL PROBLEMS		

Additional Medical History details:_____

List past surgical procedures and dates:_____

List medications you take:_____

List medications you are allergic to:_____

Allergy details (location, reaction, severity):_____

List any family medical problems: _____