



PATIENT HISTORY
(PLEASE ANSWER ALL QUESTIONS – PLEASE PRINT OR WRITE CLEARLY)

PATIENT NAME: _____ Date: ____/____/____

1. What is your chief problem at this time? _____

2. When does this problem occur? _____

3. How long has the problem been present? _____

4. Did you have an injury? Yes ____ No ____ (If no, please go to question #10)

5. Date of injury ____/____/____ Where did the injury occur? at work ____ sport ____ other _____

6. How did the injury occur? _____

7. How was the injury treated? _____

8. Who treated you? _____

9. Please list any previous doctors you have seen for your problem and the dates of treatment:

Doctor's Name: _____ Date: ____/____/____

Doctor's Name: _____ Date: ____/____/____

Doctor's Name: _____ Date: ____/____/____

10. How much time have you missed from work? _____

11. Have you had a previous injury to the same area of your body? Yes ____ No ____

12. Date of previous injury: ____/____/____ How did it occur? _____

13. List any previous surgeries.

Date: ____/____/____ Type: _____ Doctor's Name _____

Date: ____/____/____ Type: _____ Doctor's Name _____

Date: ____/____/____ Type: _____ Doctor's Name _____

14. Are you PREGNANT? Yes ____ No ____ (IF YES, MAKE SURE NO X-RAYS ARE TAKEN!)

15. Do you have any medical problems? If yes, Please indicate below:

heart ____ lung ____ nervous system ____ blood ____ cancer ____ other (list) _____

16. Are you ALLERGIC TO PENICILLIN? Yes ____ No ____ OTHER DRUG ALLERGIES _____