INNOVATIVE SPORTS MEDICINE

Patient Name _____

REASON FOR APPT:

____ SPORTS MEDICINE
____ NUTRITION/WEIGHT LOSS
____ ACUPUNCTURE
____ CHIROPRACTIC
____ MASSAGE THERAPY
____ MEDICAL PROBLEM
____ PHYSICAL THERAPY
____ PAIN MANAGEMENT
____ ALTERNATIVE MEDICINE
____ ORTHOPEDIC COMPLAINT
____ OTHER _____

IF INJURED, WHAT BODY PART: _____ SIDE OF BODY: ____ LEFT ____ RIGHT ____ BILATERAL
INJURY DATE: _____ SPECIALIZED APPT: ____ CONSULTATION OR, ____ 2ND OPINION
PLEASE DESCRIBE BRIEFLY: _____
WERE YOU SEEN IN THE EMERGENCY ROOM: ____ YES ____ NO • IF YES, WHERE: _____

CURRENT SYMPTOMS: ____ PAIN ____ SWELLING ____ STIFFNESS ____ NUMBNESS ____ WEAKNESS
HOW LONG HAVE YOU HAD THESE SYMPTOMS? _____
DIAGNOSTIC TREATMENTS: ____ X-RAYS ____ MRI ____ BLOODWORK ____ OTHER _____
PREVIOUS TREATING PHYSICIAN (NAME/PHONE): _____

PLEASE RATE THE SEVERITY OF YOUR PAIN (1 = MINOR TO 10 = SEVERE) 0 1 2 3 4 5 6 7 8 9 10
CURRENT: _____ AT WORK: _____

IS YOUR COMPLAINT A RESULT OF A WORK-RELATED INJURY/WORKER'S COMPENSATION, CAR ACCIDENT/NO-FAULT ISSUE, OR, ANY OTHER INJURY? ____ YES ____ NO • IF YES, PLEASE PROVIDE YOUR LAWYER'S NAME, PHONE AND CASE# BELOW:

_____

PAST MEDICAL HISTORY

HAVE YOU EVER HAD? *(Check all that apply.)*

____ ANXIETY
____ CORONARY ARTERY DISEASE
____ EDEMA
____ HYPERTENSION
____ LIVER DISEASE
____ OSTEOARTHRITIS
____ PROSTATE CANCER
____ AUTOIMMUNE CONDITIONS
____ SKIN CANCER
____ ASTHMA/PULMONARY CONDITION
____ DEPRESSION
____ HEARTBURN
____ HYPERTHYROIDISM
____ HYPOTHYROIDISM
____ SEIZURE
____ GASTRITIS
____ TRAUMA
____ OTHER CANCER _____
____ COPD
____ DIABETES MELLITUS
____ HYPERLIPIDEMIA
____ KIDNEY STONES
____ MIGRAINES
____ STROKE
____ ANEMIA
____ ALLERGIES (eg. Sinus, Food)
____ OTHER _____

ARE YOU CURRENTLY ON ANY MEDICATION (S)? ____ YES ____ NO

NAME: _____ NAME: _____ NAME: _____
DOSAGE: _____ DOSAGE: _____ DOSAGE: _____
FREQUENCY: _____ FREQUENCY: _____ FREQUENCY: _____

ARE YOU ALLERGIC? ____ YES ____ NO

MEDICATION: _____ FOODS: _____ SEASONAL: _____

SURGICAL HISTORY

____ TONSILS
____ APPENDIX
____ GALL BLADDER
____ OVARY
____ UTERUS
____ SPINE SURGERY: _____
____ HERNIA REPAIR
____ OTHER: _____
____ ORTHOPEDIC: _____

PATIENT'S INITIALS: _____ **DATE:** _____

Employee Review Initials

_____

Patient Name _____

FAMILY HISTORY:

____ CARDIAC DISEASE ____ DIABETES ____ OSTEOARTHRITIS
____ CANCER ____ STROKE ____ OTHER: _____

RELATIONSHIP TO SELF:
_____

SOCIAL HISTORY:

DO YOU SMOKE? ____ YES ____ NO # PACKS PER DAY _____ # YEARS _____
DO YOU CONSUME ALCOHOL? ____ YES ____ NO # DRINKS PER DAY _____ PER WEEK_____

SYSTEMS REVIEW: **DO YOU NOW HAVE, OR EVER HAD?** *(Check all that apply.)*

CONSTITUTIONAL SYMPTOMS	❑ RECENT WEIGHT CHANGE (GAIN OR LOSS) ❑ FEVER ❑ FATIGUE OR GENERAL WEAKNESS
EYES / VISION	❑ EYE DISEASE OR INJURY ❑ WEAR GLASSES OR CONTACT LENSES ❑ BLURRED OR DOUBLE VISION ❑ GLAUCOMA
EARS, NOSE, THROAT & MOUTH	❑ HEARING LOSS OR RINGING IN EARS ❑ CHRONIC SINUS PROPLEMS OR RHINITIS ❑ NOSE BLEEDS ❑ BLEEDING GUMS ❑ SORE THROAT, HOARSENESS, OR VOICE CHANGE ❑ DIFFICULTY SWALLOWING ❑ SWOLLEN GLANDS IN NECK
CARDIOVASCULAR SYSTEM	❑ HEART TROUBLE ❑ ANGINA PECTORIS (CHEST PAIN, DISCOMFORT OR TIGHTNESS) ❑ PALPITATIONS (IRREGULAR OR FORCEFUL HEART BEATS) ❑ SHORTNESS OF BREATH WHILE WALKING OR LYING FLAT ❑ SWELLING OF FEET, ANKLES, OR HANDS
RESPIRATORY SYSTEM	❑ CHRONIC OR FREQUENT COUGHING ❑ SHORTNESS OF BREATH ❑ ASTHMA OR WHEEZING ❑ COUGHING UP MUCOUS
GASTROINTESTINAL SYSTEM	❑ LOSS OF APPETITE ❑ CHANGE IN BOWEL MOVEMENTS ❑ NAUSEA OR VOMITING ❑ FREQUENT DIARRHEA ❑ PAINFUL BOWEL MOVEMENTS OR CONSTIPATION ❑ RECTAL BLEEDING OR BLOOD IN STOOL ❑ ABDOMINAL PAIN ❑ PEPTIC ULCER (STOMACH OR DUODENAL) ❑ FREQUENT HEART BURN

PATIENT'S INITIALS: _____ **DATE:** _____

Employee Review Initials
_____

DO YOU NOW HAVE, OR EVER HAD? *(Check all that apply.)* **Patient Name** _____

MUSCULOSKELETAL SYSTEM	❑ JOINT PAIN, STIFFNESS OR SWELLING ❑ WEAKNESS OF MUSCLES OR JOINTS ❑ MUSCLE PAIN OR CRAMPS ❑ BACK OR NECK PAIN ❑ COLD EXTREMITIES (HANDS OR FEET) ❑ DIFFICULTY WALKING
PSYCHIATRIC HEALTH	❑ MEMORY LOSS OR CONFUSION ❑ NERVOUSNESS OR ANXIETY ❑ DEPRESSION ❑ INSOMNIA ❑ DIFFICULTY CONCENTRATING
NEUROLOGICAL SYSTEM	❑ FREQUENT OR RECURRING HEADACHES ❑ LIGHT-HEADEDNESS OR DIZZINESS ❑ CONVULSIONS OR SEIZURES ❑ NUMBNESS OR TINGLING SENSATIONS ❑ TREMORS OR SHAKING ❑ PARALYSIS ❑ STROKE ❑ HEAD INJURY ❑ POOR BALANCE
GENITOURINARY SYSTEM	❑ FREQUENT URINATION ❑ BURNING OR PAINFUL URINATION ❑ BLOOD IN URINE ❑ CHANGE IN FORCE OF STRAIN WHEN URINATING ❑ INCONTINENCE OR DRIBBLING ❑ KIDNEY STONES ❑ SEXUAL DIFFICULTIES ❑ GENITAL INFECTIONS OR SEXUALLY TRANSMITTED DISEASE (STD) ❑ (MALE) TESTICLE PAIN OR SWELLING ❑ (FEMALE) PAIN WITH PERIODS ❑ (FEMALE) IRREGULAR PERIODS ❑ (FEMALE) VAGINAL DISCHARGE ❑ (FEMALE) # OF PREGNANCIES _____ ❑ (FEMALE) # OF MISCARRIAGES _____ ❑ (FEMALE) DATE OF LAST PAP SMEAR _____
INTEGUMENTRY SYSTEM (Skin, Hair & Nails) & BREAST HEALTH	❑ SKIN RASH OR ITCHING ❑ HAIR LOSS OR OTHER SCALP PROBLEMS ❑ CHANGE IN NAIL GROWTH OR CONDITION ❑ BREAST PAIN ❑ BREAST LUMP
ENDOCRINE SYSTEM	❑ THYROID DISEASE ❑ DIABETES: ___ INSULIN OR _____ NON-INSULIN ❑ EXCESSIVE THIRST OR URINATION ❑ HEAT OR COLD INTOLERANCE
HEMATOLOGIC & LYMPHATIC SYSTEMS	❑ BLEEDING OR BRUISING TENDENCY ❑ ANEMIA (LOW RED BLOOD CELL LEVELS) ❑ VARICOSE (ENLARGED OR TWISTED) VEINS IN LEGS ❑ PAST BLOOD TRANSFUSIONS

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