

**Musculoskeletal New Patient History** Date: \_\_\_\_\_

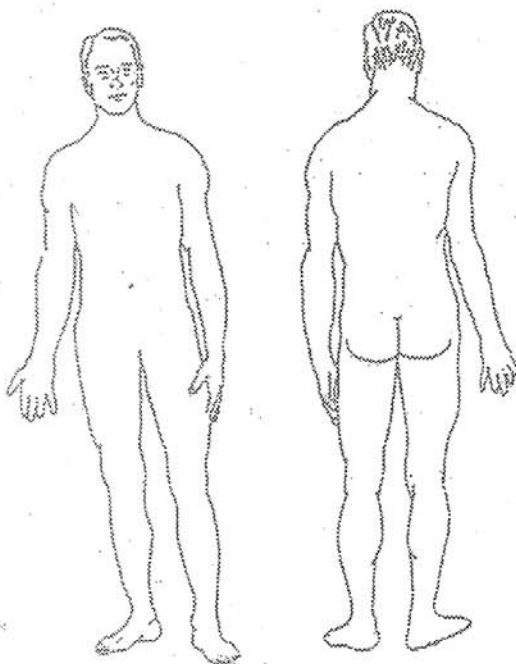
Patients name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

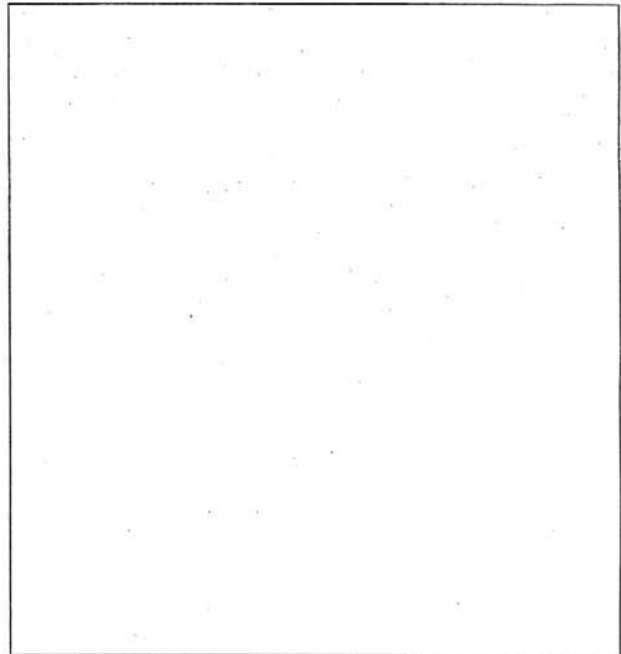
When and how did the problem occur? \_\_\_\_\_

Was this a result of an acute injury or accident? \_\_\_\_\_

**Problem Diagram:** (Please mark the areas on the diagram where you are experiencing difficulty.)



Leave Blank



**If you have pain please describe the pain sensation.** (Circle those that apply)

*Aching      Tightness      Pins & Needles      Burning      Stabbing/Sharp*  
*Shooting      Twisting      Pressure      Numbness/Tingling*

When during the day do you have your pain? \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

What daily activities does this problem affect? \_\_\_\_\_

Have you received any special testing or procedures for this problem? (Circle below)

CT Scan      MRI      EMG      X-rays      Injections      Surgery

## Review of Systems

(Circle any symptoms or findings below that you have experienced recently)

**Constitutional** = weight change, weakness, fatigue, fever, nausea

**Eyes** = vision problems, double vision

**ENMT** = hearing problems, dizziness, sinus trouble, sore throat, ringing ears

**Cardiovascular** = shortness of breath, chest pain, leg swelling, increased blood pressure

**Respiratory** = cough, coughing up blood, wheezing, asthma

**Gastrointestinal** = trouble swallowing, heartburn, vomiting, diarrhea, blood or black tar stools

**Genitourinary** = pain with urination, blood in urine, urgency, incontinence

**Musculoskeletal** = joint pain/stiffness, cramps, weakness, loss of motion

**Skin** = rash, lumps, itching, dryness, hair changes, nail changes

**Neurological** = fainting, blackouts, seizures, paralysis, weakness, numbness, memory loss,  
headaches

**Psychological** = nervousness, tension, mood changes, depression, anxiety

**Endocrine** = heat or cold intolerance, sweating, thirst, changes with hunger

**Hematology** =bruising, bleeding, transfusion reactions

**Hand Dominance**= Right \_\_\_\_\_ Left \_\_\_\_\_

## Past Medical History

Allergies to medications/foods/chemicals? \_\_\_\_\_

### Medication & Supplements List

<u>Medication</u>	<u>Dosage</u>	<u>How often Taken</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____



**Medical Illnesses** (that \_\_\_\_\_ have been Diagnosed with: circle those that apply)

*Diabetes, Asthma, High Blood Pressure, Heart Attack, Sleep Disorders*  
*Stroke, Stomach Ulcers, Cancer, Heart Murmur, HIV/AIDs, Hepatitis,*  
*Anemia, Seizures, Hyper/Hypo Thyroid, Osteoporosis, Deep Vein Thrombosis,*  
*Osteoarthritis or Rheumatoid Arthritis, Bowel or Bladder Incontinence, Broken Bones*

\*Other \_\_\_\_\_

**Injuries:** \_\_\_\_\_  
(Include broken bones, concussion, motor vehicle accidents, falls etc.)

**Surgeries:** 1) \_\_\_\_\_ **Date:** \_\_\_\_\_  
2) \_\_\_\_\_ **Date:** \_\_\_\_\_  
3) \_\_\_\_\_ **Date:** \_\_\_\_\_

**Family History of Medical Problems:** (Circle those that apply)

*Arthritis Back Problems Heart Problems Diabetes Cancer*

\*Other \_\_\_\_\_

**Social History**

**Do you exercise?** Yes / No  
**What type?** \_\_\_\_\_

**How often and how long?** \_\_\_\_\_

**Occupation** \_\_\_\_\_

**Hobbies/Interests** \_\_\_\_\_

**Do you use Tobacco, Alcohol, or Drugs? If yes, then how often?** \_\_\_\_\_