Medical Detail

Reason For Your Visit

○Wellness & Health Maintenance ☐	
○Injury, Pain Complaint, or Ailment ☐	Date Of Injury (When Did Your Pain Start?)
○Accident ☐ ❑ Automobile Related Accident ❑ Other Type Of Accident	When did the pain start? MM/DD/YYYY — State: Where Accident Occurred MM/DD/YYYY

How would you best describe the problem?
❑ Radiating
❑ Dull Ache ❑ Stiff/Tight ❑ Numb ❑ Burning
❑ Tingling ❑ Sharp/Stabbing ❑ Deep Boring ❑ Other___________

Please Provide Brief Details Of Your Injuries & Pain:

Please provide brief details of your pain /discomfort?

What are your goals of treatment?

About your condition:

Does anything make the pain feel better?
❑ Movement
❑ Ice ❑ Heat ❑ Medication (Type)
❑ Rest ❑ Walking ❑ Other___________

What makes the pain worse?
❑ Sleep
❑ Lifting ❑ Twisting ❑ Work
❑ Bending ❑ Sitting ❑ Other___________

When is your pain the worst? ❑ Mornings ❑ Evenings ❑ Throughout the day (constant)
❑ Afternoons ❑ At night

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Are there any other injuries that concern you?

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Medical History

Family History

Do you have any family history of:
❑ Cancer ❑ Diabetes ❑ Neurological Disorders ❑ Other_____
❑ Heart Problems/Stroke ❑ Rheumatoid Arthritis ❑ High Blood Pressure

Lifestyle

Are You A Smoker? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week
Do You Drink Alcohol? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week
Do You Exercise? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week

Have You Ever Been Hospitalized? ❑ Yes ❑ No	Have You Had Any Surgeries? ❑ Yes ❑ No
If Yes, Please List Dates/Details:	

Do You Have Any Allergies? ❑ Yes ❑ No ➪ Do You Require Medical Treatment For Your Allergies? ❑ Yes ❑ No

If Yes, Please Provide Details:

Do You Take Any Medications? ❑ Yes ❑ No

Please List All Medications & Dosage (How Much & How Often?)

Please Provide Any Other Medical Information You Feel The Doctor Needs To Know About

I certify to the best of my knowledge, the above information is complete and accurate

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date