



PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Height:** _____ **Weight:** _____

Chief Complaint

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous (BOTH)

SELECT ONLY ONE PRIMARY SYMPTOM AND ONE AFFECTED AREA

Primary Symptom: ☐ Pain ☐ Numbness/Tingling ☐ Fracture ☐ Stiffness ☐ Other: _____

Affected Area: ☐ Right ☐ Left ☐ Both (Bilateral)

☐ Shoulder ☐ Upper Arm ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Finger(s) ☐ Pelvis ☐ Hip ☐ Thigh ☐ Knee

☐ Lower Leg ☐ Ankle ☐ Foot ☐ Toe(s) **Pain radiates from/to:** _____

History of Present Illness

1. **Is your problem the result of an injury or accident?** ☐ No Injury ☐ Injury ☐ Injury at Work
☐ Auto Accident ☐ Sport Injury ☐ Prior Surgery

How long have the symptoms been present? _____

Describe the onset: ☐ Acute (sudden) ☐ Chronic condition (>3 months) **Onset Date:** ____ / ____ / ____

2. **Are you represented by an attorney?** ☐ Yes ☐ No **Are legal actions expected?** ☐ Yes ☐ No

Attorney Name: _____

3. **Have you had a problem like this before?** ☐ Yes ☐ No

Describe: _____

4. **Have you been seen in an ER for this problem?** ☐ Yes ☐ No

Treating ER: _____ **Date:** ____ / ____ / ____

5. **Rate the pain (0–10):** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

6. **Do the symptoms wake you from sleep?** ☐ Yes ☐ No

7. **Please describe the symptoms:** ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Shooting

8. **Timing of symptoms:** ☐ Constant ☐ Intermittent (Comes and goes)

9. **Is the problem:** ☐ Getting better ☐ Getting worse ☐ Unchanged

10. **What makes the symptoms worse?** ☐ None

☐ Squatting ☐ Kneeling ☐ Sitting ☐ Bending ☐ Stairs ☐ Twisting ☐ Moving ☐ Lying in bed ☐ Running

☐ Walking ☐ Athletics ☐ Reaching Overhead ☐ Standing ☐ Gripping ☐ Lifting

11. **Associated symptoms:** ☐ None

☐ Redness ☐ Bruising ☐ Swelling ☐ Numbness ☐ Stiffness ☐ Limping ☐ Clicking ☐ Locking ☐ Popping

☐ Tingling ☐ Weakness ☐ Giving way

Prior Testing / Treatment

Have you had any prior tests for this problem? ☐ **None** ☐ X-rays ☐ MRI ☐ CT Scan ☐ Nerve Test (EMG/NCV) ☐ Bone Scan

Have you had any prior treatment for this problem? ☐ Yes ☐ No

If yes, please check all treatments received and indicate the result:

Ice ☐ Improved ☐ Worsened ☐ Unchanged **Heat** ☐ Improved ☐ Worsened ☐ Unchanged

Rest ☐ Improved ☐ Worsened ☐ Unchanged **NSAIDS** ☐ Improved ☐ Worsened ☐ Unchanged

Muscle Relaxers ☐ Improved ☐ Worsened ☐ Unchanged **Physical Therapy** ☐ Improved ☐ Worsened ☐ Unchanged

Bracing ☐ Improved ☐ Worsened ☐ Unchanged **Surgery** ☐ Improved ☐ Worsened ☐ Unchanged

Injections ☐ Improved ☐ Worsened ☐ Unchanged **Home Exercise Program** ☐ Improved ☐ Worsened ☐ Unchanged

Other/Comments: _____
